FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 1, 1987

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FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO THE MEDICARE PROGRAM

MONDAY, JUNE 1, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 11:15 a.m., in room B-318 Rayburn House Office Building, the Honorable Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

*** NOTICE -- REVISED ***

FOR IMMEDIATE RELEASE
WEDNESDAY, MAY 27, 1987

PRESS RELEASE #15 - REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO THE MEDICARE PROGRAM TO BE HELD ON MONDAY, JUNE 1, 1987

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will conduct a hearing on Fiscal Year 1988 budget reconciliation issues relating to the Medicare program. The hearing will be held on Monday, June 1, 1987, beginning at 11:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Budget reconciliation legislation will include a broad range of Medicare provisions. The Committee's hearings on reconciliation began on February 25, 1987, with a presentation by Secretary Bowen. Six additional Subcommittee hearings have been held since then. This final hearing will discuss a number of additional proposals which may be incorporated into this legislation."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The Budget Resolution for Fiscal Year 1988 adopted by the House includes Medicare reconciliation savings of \$1.5 billion in FY 1988, \$2.7 billion in FY 1989, and \$4.0 billion in FY 1990. The Resolution adopted by the Senate includes reconciled Medicare savings of \$3.0 billion in FY 1988, \$3.5 billion in FY 1989, and \$4.6 billion in FY 1990. The hearing will address a number of issues which will be considered by the Subcommittee in developing reconciliation legislation.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, June 26, 1987, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman STARK. The subcommittee will come to order.

Today, the subcommittee continues its consideration of the fiscal year 1988 budget reconciliation issues relating to the Medicare program.

The legislation will include a broad range of Medicare provisions. Our hearings began on February 25 this year with a presentation by Secretary Bowen, and since then six additional subcommittee hearings have been held.

Our hearing this morning will focus on three additional issues: uniform hospital reporting, nursing home standards, and State health insurance risk pools.

Uniform reporting by hospitals is a particularly timely issue given the need to develop reconciliation legislation. For the last 2 years, the subcommittee has devoted substantial time to debating issues which could have been readily resolved if more timely and more comprehensive data had been available.

Both the Medicare program and the hospital industry deserve equitable treatment, particularly if payments to hospitals are being changed or reduced. I cannot see how we can even hope to reach those goals without an information system based upon uniform, comprehensive, and current information.

Nursing home standards are also an important part of the subcommittee's continuing concern with the quality of medical services delivered to Medicare beneficiaries. Last year, I introduced H.R. 5712 to improve the quality of care in nursing homes. This bill was based upon the recommendations in a report by the Institute of Medicine entitled "Improving the Quality of Care in Nursing Homes." I plan to introduce a similar bill soon, and I hope we can move forward to enact legislation in this area this year.

Many people with chronic and disabling diseases now face virtually insurmountable obstacles in obtaining health insurance. State health insurance risk pools present one potential option for resolving this problem. These pools have now been established in 13 States. Connecticut, in particular, assured access to the pool by all of its citizens. We need to explore this option, as well as other alternatives, to assure the handicapped and those with chronic diseases access to the health coverage which they need.

I will look forward to hearing from our witnesses on these three important topics, and I might ask at this time, in preparation for beginning our hearings, for the first panel, which will discuss uniform reporting and will consist of John Ferman, the executive vice president of the California Association of Hospitals and Health Systems; Ms. Carolyn Scanlan, the executive vice president of the Hospital Association of New York State; and Mr. Dick Clarke and Mr. Ronald Kovener, the president and vice president of the Healthcare Financial Management Association of Washington, D.C.

If you all would like to come on up to the witness table. I understand that we have several members on their way.

When we have our second member here, we will ask unanimous consent that your prepared testimony be put in the record in its entirety, and ask if you would like to summarize or expand on your prepared testimony at this time. If you would not mind, keep your testimony to about 5 minutes, and we will try and explore more during our subsequent inquiries. If the clerk will record this, we will ask unanimous consent that your comments be included in the record when we open in a few minutes.

John, would you want to start?

STATEMENT OF JOHN FERMAN, EXECUTIVE VICE PRESIDENT, CALIFORNIA ASSOCIATION OF HOSPITALS & HEALTH SYSTEMS

Mr. **Ferman**. Thank you, Mr. Chairman.

I am John Ferman with the California Association of Hospitals and Health Systems, formerly the California Hospital Association. I will highlight a few of the points we raise in our testimony, and expand a little on some of the closing suggestions.

In 1972, California enacted a uniform accounting, reporting and disclosure program. It took 2 years to develop the uniform accounting system, along with regulations supporting that system.

Chairman **Stark**. Would you suspend for just a moment? I would just like the record to show that Mr. Moody is here, and we are asking unanimous consent that the Chair's opening statement, previously read with great emotion, be entered into the record.

Mr. **Moody**. Without objection.

Chairman **Stark**. And that the prepared testimony of the witnesses will be inserted in the record, and they may proceed to summarize their testimony in any manner they are concerned with, and that Mr. Moody did not have an opening statement.

Without objection, then, please proceed, John. Thank you.

Mr. **Ferman**. Mr. Moody, I am John Ferman with the California Association of Hospitals.

Our program, of uniform accounting, reporting and disclosure was enacted in 1972. It took about 2 years to develop the accounting system, along with the implementing regulations, and then another 3 years to completely phase in the annual reporting systems. So it was 5 years later that we had the first full year of disclosure reports.

The program is run by the office of statewide health planning and development, Health and Welfare Agency, and for fiscal year 1986–87 costs about $3.8 million for the entire program.

Over the years, there were refinements and additions to the annual disclosure report. The patient discharge abstract reports were added January 1, 1986, and in 1980 a quarterly reporting requirement was implemented.

The annual disclosure reports are available about 9 to 10 months after the close of the fiscal year, and the quarterly reports are available about 105 days after the close of the calendar quarter. They are published in a formal report by the department within 6 months of the close of the calendar quarter.

In terms of the reactions and the impact, there are a number of dimensions. Obviously, from the hospital perspective, while there was some early and continuingly concern and anxiety, most has now virtually disappeared from the hospital perspective. These documents are used in planning, and marketing strategies and program evaluations by the individual hospitals, and in a competitive environment they are a very valuable tool. From the public, they make a more informed consumer, not the private consumer but the purchasers of group health care. PPOs, HMOs, other large purchasers, companies use them.

One of the benefits of this from our perspective is that it has taken the debate on cost containment out of the public arena, into the private arena.

From the association's perspective it's a very valuable tool. We no longer have to argue as to whose data are right. We have one statewide uniform data set. It is audited; it is produced by an independent agency, and so we can move off justifying the quality and reliability of the data to what the data show.

In terms of what this may mean for a national hospital data set, a couple of suggestions: One, we have concluded that the Medicare cost report is inadequate and very untimely. Two-and-a-half, three years late does not allow for responsible policy development. We think at a minimum there ought to be an establishment of a major task force to review, revise, and streamline the Medicare cost report, move it away from cost reimbursement and make it focus on the Medicare perspective pricing system.

As an interim, though, we need to speed up the availability data and information from the Medicare care reports, such as sample cost reports as proposed by ProPAC or some other way to create a more timely pool of information. If that fails, we suggest a quarterly reporting requirement, summary hospital data. You do not need a uniform accounting system to accomplish this, but it will provide for some reasonably reliable information as to the condition and effects of the prospective payment system on hospitals.

We would urge that the quarterly reporting requirement be discontinued following the implementation of the revised and streamlined annual hospital report.

We suggest that if individual hospital data is to be released that hospitals be allowed to review and critique that data similar to the way they are in the PRO mortality data release reports. Finally, they should exempt hospitals in States with comparable reporting requirements.

In closing, we urge very prompt attention to this. Major changes are occurring in the hospital industry as a result of moving to a national rate, and to make policy decisions on data that is 3 years old is an abandonment of a public policy responsibility.

Thank you.

[The statement of Mr. Ferman follows:]

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

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Testimony
of the
California Association of Hospitals and Health Systems

on

UNIFORM HOSPITAL REPORTING
before the
Subcommittee on Health
of the
Committee on Ways and Means

June 1, 1987

Mr. Chairman and Members, I am John Ferman, Executive Vice President of the California Association of Hospitals and Health Systems (CAHHS), formerly the California Hospital Association. On behalf of our 480 member institutions, I am pleased to have been asked to share with you our experiences relative to uniform hospital accounting, reporting and disclosure. We are aware that the Subcommittee is considering requiring some form of timely uniform hospital reporting in an effort to quickly assess the fiscal impact of major programmatic changes on hospital health care delivery financing. I would like to share California's experiences and then suggest issues for your consideration in developing a uniform hospital reporting program.

California Health Facilities Disclosure Act

Cost containment pressures prompted the California hospital industry to sponsor legislation entitled the California Hospital Disclosure Act in early 1971. It was passed the same year and became effective in 1972. The name was changed to the California Health Facilities Disclosure Act in 1974.

The bill established a uniform accounting, reporting and disclosure system for California hospitals and created a seven-member California Hospital Commission (four providers and three public members). The commission's operating funds were provided through an assessment on the hospitals based on their total operating costs. The commission took two years to develop its regulations and an accounting manual for hospitals. The reporting system became effective July, 1974. The reporting system was phased in for all hospitals over a three-year period. The first annual inventory of hospital financial and statistical information was published by the commission in the spring of 1977.

Representing California Hospitals and their Health Systems

Annual Reporting Requirements

As enacted, the law required every hospital (long-term care facilities were added by the Legislature in 1974) to file within four months after the close of the hospital's fiscal year the following reports: a balance sheet; a statement of income expenses and operating surpluses or deficits; a statement detailing the source and application of funds; a statement reporting the above information for each separately licensed health facility operated or maintained by the reporting organization; a departmental cost allocation report of health facility expenditures; and an "accurate and sufficiently detailed statistical report".

In later years the annual report was amended to expand the reporting requirements to include: a statement detailing patient revenue by payor, including Medicare and Medi-Cal and other payors; a statement detailing changes of financial position and capital financing status; and a hospital discharge abstract record for every discharge. The latter discharge report was required to be filed semi-annually within six months after the end of each semi-annual period beginning six months after January 1, 1986.

Quarterly Reporting Requirements

In 1980, hospitals' reporting requirements were expanded to include quarterly reporting of summary financial and statistical data to monitor the hospital industry's efforts to voluntarily contain costs. The summary data requirements were themselves revised over the subsequent years. The quarterly data, by calendar quarter, are due within 45 days of the end of every calendar quarter and include:

(a) Number of licensed beds;
(b) Average number of available beds;
(c) Average number of staffed beds;
(d) Number of discharges;
(e) Number of inpatient days;
(f) Number of outpatient visits;
(g) Total operating expenses;
(h) Total inpatient gross revenues;
(i) Total outpatient gross revenues;
(j) Total deductions from revenue, including bad debt, charity care, and Medicare and Medi-Cal contractual allowances;
(k) Total capital expenditures;
(l) Total net fixed assets;
(m) Total number of inpatient days, outpatient visits and discharges by payer source;
(n) Total net patient revenues by payer source.

The California statute is attached as Exhibit 1 for your information. Also included as Exhibit 2 is the quarterly financial and statistic form with accompanying directions.

Program Costs

The FY 1987-88 budget proposes total programmatic costs of $3,864,000 and approximately 57 full-time personnel. It is estimated that during FY 1987-88, the health facilities data program now under the Office of Statewide Health Planning and Development (OSHPD) will process over 83,000 information requests, 610 annual financial reports, 2,430 quarterly financial and utilization reports, 3,500,000 discharge abstract reports, 1,270 annual long-term care reports and 20 research reports. OSHPD estimates that current year costs of the quarterly reporting component of the data program is about $500,000 and that it costs each hospital about $500 per year to complete the quarterly reports.

Hospital Response and Implications

As enacted, and later during implementation, there were varying levels of anxiety and concern relative to the reporting component system. On one end of the spectrum there were hospital leaders who felt that the reporting requirements did not go far enough, that other data should be collected. These data included case mix and quarterly reports and other suggestions which ultimately were added to the reporting requirements. At the other end of the spectrum were those who felt that the statute should never have been enacted. Specific implementation problems of the uniform reporting requirements were that:

1. The California Health Facility Commission (CHFC) utilized non-accounting staff to review reports and communicate with hospitals in the initial years. This led to confusion, inconsistencies and an adverse relationship, later rectified as more sophisticated personnel were hired.

2. In order to develop a uniform reporting system, a uniform accounting system was a prerequisite. Although creating a uniform accounting system had many advantages for hospitals, it was a difficult transition. Many hospitals did not keep records that were necessary in operating a financially successful facility.

3. An edit system was created to help provide for accuracy in reporting. In the early years the software program was not very sophisticated; minor errors caused the report to be returned for a complete recalculation by the hospital. This delay in the processing time resulted in the acceptance of some errors to avoid too many delays. Improvements to the computer software packages have since eliminated the problems.

4. The annual reports were not tied to reimbursement until July 1980, when Medi-Cal developed a reimbursement limitation which utilized data from the CHFC annual reports. This caused hospitals to begin taking the reported data more seriously and resulted in a reduction in the number of inaccuracies.

There was a fair amount of anxiety over the disclosure component of the program. The early concerns were that inappropriate or onerous conclusions would be reached through the evaluation of the data. In fact, the single biggest issue around which the industry focused from the program's inception until 1986 was the manner in which the data were used by the independent state commission that was responsible for the operation of the program. As envisioned at the program's inception, the California Hospital Commission, later changed to the CHFC (now 13 members) would serve an administrative function for the collection and reporting of summary data without any interpretative elements. The role of the Commission was simply to make the data available to those who wished to receive it and perform their own analysis. However, the Commission assumed a public policy advocacy role which encouraged increased state regulation of the hospital industry. The Commission used the data in what many in the industry felt was a manipulative way to justify regulatory controls. In response to this, the industry was able to include in the Medi-Cal and private sector reform legislation of 1982, a sunset of the Commission effective January 1, 1986. Although there were subsequent efforts to repeal or extend the sunset, they were unsuccessful. In 1986, the authority for the Health Facility Disclosure Act was transferred to OSHPD, a department of the Health and Welfare Agency. Since then, there has been little, if any, controversy or criticism.

No major problems were encountered with the implementation of the quarterly reporting. The smooth transition to this requirement can be attributed to the fact that the uniform accounting system was already in place and operational as a result of the annual reporting requirement. Therefore, only data which was already required to be maintained was now reported more frequently. However, there have been some problems with the reporting of contractual allowances on a quarterly basis. However, awareness of a hospital's contractual allowances on a regular basis, at least monthly, is essential in making any sound financial decision.

Disclosure

As the law currently stands, OSHPD makes available at cost comprehensive group and individual reports. The annual data report for a full fiscal year, June 30 through June 29, requires about one year. That is, the 11th Annual Hospital Disclosure Report, covering fiscal years ending between June 30, 1985 and June 19, 1986, is just now being released. Disclosure of quarterly data usually follows five to six months after close of the respective calendar quarter. Further individual hospital data are available to any individual, company, etc. that wishes to pay the cost of duplicating the reports. Thus, the data are available to individual hospitals which want information relative to their competitors, and are available to the various committees of the Legislature. From a hospital industry perspective, I feel safe in saying that while there were early concerns about the potential abuse of the data and how the data would be used in a public policy arena, we have found the data to be very valuable in articulating and advocating hospital public policy issues. Up until the reporting and disclosure program, the California Hospital Association had a voluntary quarterly reporting program which had at most 60 percent participation by the industry. As every trade association experiences, we had a number of bills and issues each year which required empirical evidence in support of our position; however, what data we had were incomplete and did not even constitute statistically valid sample. Further, our information was always suspect because it was data reported to the trade association and was not verifiable. With the enactment of the disclosure act, this was eliminated. We had 100 percent participation, we had a uniform reporting of verifiable data, it was audited data, and it was collected by an independent agency of government, thus, eliminating charges that it might have been manipulated, etc. When we go before committees or before the public we no longer have to spend the energy and the time to establish the credibility of the data, the data has a built in credibility.

The uniform hospital reporting and disclosure program cuts both ways. It allows public scrutiny and hospital performance assessments. It also allows the hospital industry to better prepare and articulate our perspectives on issues.

Suggestions

Based on our experience, I would like to make a few suggestions on the assumption that the Subcommittee conceptually supports the uniform hospital reporting requirements.

1. Clearly, a more timely national hospital data base is now provided by the Medicare cost reports.

2. Timeliness versus reliability and accuracy is a key consideration. If we had to do it all over again, we probably would have urged a quartely reporting program as an interim step toward an annual reporting system. Our annual system provides a full year of detailed audited data, approximately 12 months later. With our quarterly system and summary, unaudited data provides a rolling year snapshot, six months later. A six-month delay is a reasonable price to pay for increased reliability and details.

3. While a uniform accounting system is not a prerequisite for a quarterly reporting system, the ease with which California hospitals adapted to the quarterly reporting requirement is directly due to the existence of a uniform accounting system.

4. Initial focus should be devoted toward the establishment of a uniform hospital quarterly reporting program. This program should be implemented as soon as possible. The reports should be required to be filed no earlier than within 45 days of the close of the calendar quarter. The administering agency or commission should be required to report within 90 days of the close of the respective calendar quarter summary financial and statistical information. At the same time, the responsible

administrative agency or commission should be required to make available at cost to the public complete computer tapes of the quarterly reports.

5. Congress should direct the Administration and the Prospective Payment Assessment Commission (ProPAC) to report back by January 1, 1988, on their recommendations for revising the Medicare hospital cost report to reflect the fact that Medicare payments have moved from a cost reimbursement basis to a prospective payment basis. The recommendation is based on the assumption that much of the data collected vis-a-vis the Medicare cost reports are no longer needed in a prospective payment environment. The Subcommittee should include in legislation the specific purposes that the revised annual report should serve.

6. The quarterly reports should be discontinued following implementation of the revised Medicare cost reports.

7. Learning from the Peer Review Organization's hospital mortality reporting process requires increased sensitivity to allowing hospitals at least a 30-day review and critique of any hospital-specific disclosure reports.

8. Any federal reporting requirements should exempt hospitals in states which have a comparable reporting system. The administering federal agency should collect the reports from the respective state's collection agency.

In conclusion, we feel that timely reporting of hospital financial and utilization data will allow Congress to more quickly anticipate and respond to the unintended consequences of changes in the Medicare program. It will allow federal health policy makers to monitor the effects of changes in state Medicaid programs. It will allow accurate assessments of changes in the costs of uncompensated care. It will allow these and many other assessments and evaluations now unavailable.

We remain available to provide whatever assistance is necessary.

EXHIBIT 1

PART 1.8. HEALTH DATA AND ADVISORY COUNCIL CONSOLIDATION

Section

443. Popular name of part.
443.10. Legislative findings, declaration and intent.
443.20. California health policy and data advisory commission; creation; membership; terms.
443.21. Definitions.
443.22. Reference to this part.
443.23 Meetings.
443.24. Per diem and expenses.
443.25. Executive secretary; staff to commission.
443.26. Powers and duties of commission; committees; compensation and expenses; written response; appeal over disagreements.
443.30. Single state agency; collection of health facility or clinical data; consolidation of reports.
443.31. Health facilities; reports and forms; patient's rights of confidentiality; hospital discharge abstract data record.
443.32. Quarterly summary financial and utilization data reports; contents; copies.
443.33. Time for filing reports required by §§ 443.30, 443.31; copies.
443.34. Health facilities; accounting and auditing systems; modifications to discharge data reporting requirements; reporting provisions; county hospital systems financial reporting requirements.
443.35. File of reports; public inspection; certified copies; summaries; public liaison.
443.36. Penalties; disposition.
443.37. Petition for review; hearing; judicial review; subpoena powers.
443.38. District hospitals; completeness of disclosure.
443.40. Regulations to remain in effect.
443.41. Transfer of funds.
443.42. Transfer of officers and employees other than temporary employees.
443.43. Transfer of real and personal property of California health facilities commission.
443.44. Contracts.
443.45. Administration; rules and regulations.
443.46. Duration of part.

Part 1.8 was added by Stats.1984, c. 1326, p. ——, § 7.

Part 1.8 is repealed on Jan. 1, 1990 by the provisions of § 443.46.

§ 443. Popular name of part

This part shall be known as the Health Data and Advisory Council Consolidation Act.

(Added by Stats.1984, c. 1326, p. ——, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.10. Legislative findings, declaration and intent

The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the health care marketplace and in the manner in which health facilities are reimbursed by government and private third party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and manner in which data are collected from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in a single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities which are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission and the State Advisory Health Council, and to create a single advisory commission to assume consolidated data collection and planning functions.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office, with the advice of the advisory commission, shall annually review this data for need and shall revise, add, or delete items as necessary. The commission and the office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this part, to continue the uniform system of accounting and reporting established by the commission and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1985, c. 1021, p. —, § 1.5.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.20. California health policy and data advisory commission; creation; membership; terms

There is hereby created the California Health Policy and Data Advisory Commission to be composed of 11 members.

The Governor shall appoint seven members, one of whom shall be a hospital chief executive officer, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment health care service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member.

The chairperson shall be designated by the Governor. The Governor shall designate four original appointments which will be for four-year terms. The Governor shall designate three original appointments which shall be for two-year terms. The Speaker of the Assembly shall designate one original appointment which will be for two years and one original appointment which will be for four years. The Senate Rules Committee shall designate one original appointment which will be for two years and one original appointment which will be four years. Thereafter, all appointments shall be for four-year terms.

In addition to the 11 original appointees to the commission, the chairperson of the Advisory Health Council on December 31, 1985, and the chairperson of the California Health Facilities Commission on December 31, 1985, shall also serve four-year terms. During their terms when the commission shall have 13 members, they shall be full voting representatives.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

Derivation: Welf. & Inst.C. former § 14125, added by Stats.1983, c. 1120, p. —, § 2.

§ 443.21. Definitions

As used in this part, the following terms mean:

(a) "Commission" means the California Health Policy and Data Advisory Commission.

(b) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(c) "Hospital" means all health facilities except skilled nursing and intermediate care facilities.

(d) "Office" means the Office of Statewide Health Planning and Development.

(Added by Stats.1985, c. 1021, p. ——, § 2.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

1985 Legislation.

Former § 443.21, added by Stats.1984, c. 1326, p. ——, § 7, defining "office" and "commission", was repealed by Stats.1985, c. 1021, p. ——, § 1.5.

§ 443.22. Reference to this part

On and after January 1, 1986, any reference in this part or Part 1.5 (commencing with Section 437) to the Advisory Health Council shall be deemed a reference to the California Health Policy and Data Advisory Commission.

(Added by Stats.1984, c. 1326, p. ——, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.23. Meetings

The California Health Policy and Data Advisory Commission shall meet at least once every two months, or more often if necessary to fulfill its duties.

(Added by Stats.1984, c. 1326, p. ——, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.24. Per diem and expenses

The members of the commission shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.

(Added by Stats.1984, c. 1326, p. ——, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.25. Executive secretary; staff to commission

The commission may appoint an executive secretary subject to approval by the Secretary of Health and Welfare. The office shall provide such other staff to the commission as the office and the commission deem necessary.

(Added by Stats.1984, c. 1326, p. ——, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.26. Powers and duties of commission; committees; compensation and expenses; written response; appeal over disagreements

The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data.

(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

(e) Conduct public meetings for the purposes of obtaining input from health facilities, data users, and the general public regarding this part and Part 1.5 (commencing with Section 437).

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.

(h) Advise the office on the format of individual health facility reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Part 1.5 (commencing with Section 437).

As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.

The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.30. Single state agency; collection of health facility or clinical data; consolidation of reports

(a) Effective January 1, 1986, the Office of Statewide Health Planning and Development shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) That data required by the office pursuant to Section 439.2.

(2) That data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Those data items formerly required by the California Health Facilities Commission that are listed in Sections 443.31 and 443.32.

(b) The office shall consolidate any and all of the reports listed under this section or Sections 443.31 and 443.32, to the extent feasible, to minimize the reporting burdens on hospitals. Provided, however, that the office shall neither add nor delete data items from the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or regulation or judicial decision.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.31. Health facilities; reports and forms; patient's rights of confidentiality; hospital discharge abstract data record

Every organization which operates, conducts, or maintains a health facility and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office which shall be in accord where applicable with the systems of accounting and uniform reporting required by this part, except the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 443.34 are not required to report revenue by revenue center.

(d) A statement detailing changes in financial position and capital financing status, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a) * * *, (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 443.34.

(f) The office shall consult with the County Hospital Committee of the California Hospital Association, the County Supervisors Association of California, and the California Association of Public Hospitals to improve the accuracy of indigent care revenue reporting and shall present legislative or regulatory recommendations for such improvements by March 30, 1985.

(g) A Hospital Discharge Abstract Data Record which includes all of the following:

(1) Date of birth.
(2) Sex.
(3) Race.
(4) Zip code.
(5) Admission date.
(6) Source of admission.
(7) Type of admission.
(8) Discharge date.
(9) Principal diagnosis.
(10) Other diagnoses.
(11) Principal procedure and date.
(12) Other procedures and dates.
(13) Total charges.
(14) Disposition of patient.
(15) Expected source of payment.

It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner.

A hospital or its designee shall semiannually file the Hospital Discharge Abstract Data Record not later than six months after the end of each semiannual period, commencing six months after January 1, 1986. A hospital may submit the Hospital Discharge Abstract Data Record in a computer tape format, and a hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1984, c. 1338, p. —, § 1, operative Jan. 1, 1985; Stats.1985, c. 756, p. ——, § 1; Stats.1985, c. 1021, p. ——, § 4.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

1984 Legislation.

Section 5 of Stats.1984, c. 1338, p —, provides

"Sections 1 and 2 of this act shall become operative only if Senate Bill 181 of the 1983–84 Regular Session of the Legislature [Stats.1984, c. 1326] is chaptered and becomes effective and as enacted adds Sections 443.31 and 443.34 to the Health and Safety Code [so added] and, in that case, Sections 1 and 2 of this act shall become operative January 1, 1985."

1985 Legislation.

Amendment of this section by § 2 of Stats.1985, c. 756, p. ——, failed to become operative under the provisions of § 6 of that Act.

Amendment of this section by § 3 of Stats.1985, c. 1021, p. ——, failed to become operative under the provisions of § 10 of that Act.

Effect of amendment of section by two or more acts at the same session of the legislature, see Government Code § 9605.

§ 443.32. Quarterly summary financial and utilization data reports; contents; copies

Commencing with the first calendar quarter of 1986, summary financial and utilization data previously reported to the Health Facilities Commission pursuant to Section 441.185 shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(a) Number of licensed beds.

(b) Average number of available beds.

(c) Average number of staffed beds.

(d) Number of discharges.

(e) Number of inpatient days.

(f) Number of outpatient visits.

(g) Total operating expenses.

(h) Total inpatient gross revenues.

(i) Total outpatient gross revenues.

(j) Total deductions from revenue, including bad debts, charity care, and Medicare and Medi-Cal contractual allowances.

(k) Total capital expenditures.

(*l*) Total net fixed assets.

(m) Total number of inpatient days, outpatient visits, and discharges by payer source, including Medi-Cal, Medicare, and other sources.

(n) Total net patient revenues * * * by payer source, including, but not limited to, Medicare, Medi-Cal, and * * * other payers.

Hospitals reporting pursuant to subdivision (d) of Section 443.34 may provide the items in subdivisions (g), (h), (i), * * * (j), and (n) of this section on a group basis, as described in subdivision (d) of Section 443.34.

The office shall make available at cost, to all interested parties, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1985, c. 756, p. ——, § 3; Stats.1985, c. 1021, p. ——, § 6.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

1985 Legislation.

Amendment of this section by § 4 of Stats.1985, c. 756, p ——, failed to become operative under the provisions of § 6 of that Act.

Amendment of this section by § 5 of Stats.1985, c. 1021, p. ——, failed to become operative under the provisions of § 10 of that Act.

Effect of amendment of section by two or more acts at the same session of the legislature, see Government Code § 9605.

§ 443.33. Time for filing reports required by §§ 443.30, 443.31; copies

(a) The reports required by subdivisions (a), (b), and (c) of Section 443.31 shall be filed with the office within four months after the close of the filing organization's fiscal year and shall be available from the office no later than three months after the date upon which the report was filed.

(b) The reports required by subdivision (d) of Section 443.31 shall be filed annually by each hospital or its designee not later than six months after the end of the calendar year, and shall be available from the office no later than six months after the date upon which the report was filed.

(c) The reports referred to in paragraph (2) of subdivision (a) of Section 443.30 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date upon which the report was filed.

(d) The office shall make available at cost, to all interested parties, a hard copy of any health facility report referred to in subdivision (a), (b), or (c) or subdivision (d) or (g) of Section 443.31 of this section and in addition to hard copies, shall make available at cost, computer tapes of the health facility reports referred to in subdivision (a), (b), or (c), unless the office determines that an individual patient's rights of confidentiality would be violated. In addition, the office shall provide at no cost, one copy of each individual health facility report or a computer tape thereof to each area health planning agency.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1985, c. 1021, p. ——, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.34. **Health facilities; accounting and auditing systems; modifications to discharge data reporting requirements; reporting provisions; county hospital systems financial reporting requirements**

(a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office with the advice of the Health Policy and Data Advisory Commission.

(b) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this part if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this part. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified in Section 443.31.

(d) Reporting provisions for health facilities. The office, with the advice of the commission, shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner which is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 443.31. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

The office, with the advice of the commission, shall adopt comparable modifications to the financial reporting requirements of this part for county hospital systems consistent with the purposes of this part.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1984, c. 1338, p. —, § 2, operative Jan. 1, 1985; Stats.1985, c. 756, p. ——, § 5.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

1984 Legislation.

Section 5 of Stats.1984, c. 1338, p. —, provides:

"Sections 1 and 2 of this act shall become operative only if Senate Bill 181 of the 1983–84 Regular Session of the Legislature [Stats.1984, c. 1326] is chaptered and becomes effective and as enacted adds Sections 443.31 and 443.34 to the Health and Safety Code [so added] and, in that case, Sections 1 and 2 of this act shall become operative January 1, 1985."

Underline indicates changes or additions by amendment

§ 443.35. File of reports; public inspection; certified copies; summaries; public liaison

(a) The office, with the advice of the commission, shall maintain a file of all the reports filed under this part at its Sacramento office. Subject to any rules, the office, with the advice of the commission, may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, with the exception of hospital discharge abstract data which shall be available for public inspection unless the office determines that an individual patient's rights of confidentiality would be violated.

(b) Copies certified by the office as being true and correct copies of reports properly filed with the office pursuant to this part, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission which participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(c) The office, with the advice of the commission, shall compile and publish summaries of the data for the purpose of public disclosure. The commission shall approve the policies and procedures relative to the manner in which data is disclosed to the public. * * * The office, with the advice of the commission, may initiate and conduct studies as it determines will advance the purposes of this part.

(d) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director and the commission with an annual report on changes that can be made to improve the public's access to data.

(e) In addition to its public liaison function, the office shall continue the publication of aggregate industry and individual health facility cost and operational data published by the California Health Facilities Commission as described in subdivision (b) of Section 441.95 as that section existed on December 31, 1985. This publication shall be submitted to the Legislature not later than March 1 of each year commencing with calendar year 1986 and in addition shall be offered for sale as a public document.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1985, c. 1021, p. —, § 8.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.36. Penalties; disposition

(a) Any health facility which does not file any report as required by this part with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office, with the advice of the commission.

(b) Any health facility which does not use an approved system of accounting pursuant to the provisions of this part for purposes of submitting financial and statistical reports as required by this part shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money which is received by the office pursuant to this section shall be paid into the General Fund.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.37. Petition for review; hearing; judicial review; subpoena powers

Any health facility affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within such greater time as the office, with the advice of the commission, may allow, and shall specifically describe the matters which are disputed by the petitioner.

A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, * * * a hearing officer employed by the Office of Administrative Hearings, or a committee of the commission chosen by the chairperson for this purpose. If held before an employee of the office or a committee of the commission, the hearing shall be held in accordance with such procedures as the office * * *, with the advice of the commission, shall prescribe. If held before a hearing officer employed by the Office of Administrative Hearings, the hearing shall be held in accordance with * * * Chapter 5 (commencing with Section 11500) of Division 3 of the Government Code. The employee, hearing officer, or committee shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office * * * shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office * * * shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

The employee of the office * * *, the hearing officer employed by the Office of Administrative Hearings, the Office of Administrative Hearings, or the committee of the commission, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Section 11510 of the Government Code.

(Added by Stats.1984, c. 1326, p. —, § 7. Amended by Stats.1985, c. 1021, p. —, § 9.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.38. **District hospitals; completeness of disclosure**

Notwithstanding any other provision of law, the disclosure aspects of this part shall be deemed complete with respect to district hospitals, and no district hospital shall be required to report or disclose any additional financial or utilization data to any person or other entity except as is required by this part.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.40. **Regulations to remain in effect**

On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission which relate to functions vested in the Office of Statewide Health Planning and Development and which are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this part, as determined by the office, unless and until readopted, amended, or repealed by the Office of Statewide Health Planning and Development following review and comment by the commission.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.41. **Transfer of funds**

Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the office the unexpended balance of funds as of January 1, 1986, in the California Health Facilities Commission Fund, available for use in connection with the performance of the functions of the California Health Facilities Commission to which it has succeeded pursuant to this part.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.42. **Transfer of officers and employees other than temporary employees**

All officers and employees of the California Health Facilities Commission who, on December 31, 1985, are serving the state civil service other than as temporary employees, and engaged in the performance of a function vested in the Office of Statewide Health Planning and Development by this part shall be transferred to the Office of Statewide Health Planning and Development. The status, positions, and rights of such persons shall not be affected by the transfer and shall be retained by them as officers and employees of the Office of Statewide Health Planning and Development, pursuant to the State Civil Service Act except as to positions exempted from civil service.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.43. Transfer of real and personal property of California health facilities commission

The Office of Statewide Health Planning and Development shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, or other property, real or personal, held for the benefit or use of the California Health Facilities Commission for the performance of functions transferred to the Office of Statewide Health Planning and Development by this part.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.44. Contracts

The Office of Statewide Health Planning and Development may enter into such agreements and contracts with any person, department, agency, corporation, or legal entity as are necessary to carry out the functions vested in the office by this part or any other law.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.45. Administration: rules and regulations

The office shall administer this part and shall make all rules and regulations necessary to implement the provisions and achieve the purposes stated herein. The commission shall advise and consult with the office in carrying out the administration of this part.

(Added by Stats.1984, c. 1326, p. —, § 7.)

Part 1.8 is repealed on Jan. 1, 1990, under the terms of § 443.46.

§ 443.46. Duration of part

This part shall remain in effect only until January 1, 1990, and as of that date is repealed unless a later enacted statute chaptered prior to that date extends or deletes that date.

(Added by Stats.1984, c. 1326, p. —, § 7.)

PART 1.85. HEALTH CARE PILOT PROJECT

Section

444. Legislative findings and intent.
444.1. Definitions.
444.2. Establishment and administration of pilot program.
444.3. Applications; forms.
444.4. Direction of laboratories; qualifications of physicians and surgeons.
444.5. Statistical data and patient information; confidentiality; suspension or withdrawal of approval.
444.6. Technical advisory committee; members; conflict of interest; reimbursement for expenses; duties.
444.7. Report to legislature.
444.8. Requirements; protocols; informed consent.
444.9. Regulations.
444.10. Fee.
444.11. Duration of part.

Part 1.85 was added by Stats.1985, c. 1074, p. ——, § 1.

Addition of Part 1.85, Health Care Pilot Project, by Stats.1985, c. 1075, failed to become operative under the provisions of § 7 of that Act.

Repeal

Part 1.85 is repealed effective Jan. 1, 1989 by the terms of § 444.11.

§ 444. Legislative findings and intent

The Legislature hereby finds and declares all of the following:

(a) Currently cardiac catheterization diagnostic procedures are performed almost exclusively in a general acute care hospital setting, generally on an inpatient basis. The procedure is relatively costly, as are many of the inpatient diagnostic procedures that rely heavily on expensive high technology.

(b) Recent advances in technology indicate the feasibility of performing high quality, safe diagnostic cardiac catheterization procedures in a freestanding cardiac catheterization laboratory. This could lower the cost of care for the diagnostic procedure, as well as obviate the need in many instances for an expensive hospital stay.

(c) Prior to amending the law to permit cardiac catheterization to be performed in a nonhospital setting, it is the intent of the Legislature that cardiac catheterization performed in freestanding cardiac catheterization laboratories be evaluated on a pilot project basis and demonstrated to be a safe, high quality, cost-effective diagnostic modality.

(d) It is further the intent of the Legislature that a pilot program be authorized under the supervision of the Office of Statewide Health Planning and Development, and that the office report back to the Legislature its findings and recommendations on the pilot program.

(Added by Stats.1985, c. 1074, p ——, § 1.)

1985 Legislation. Addition of this section by § 1 of Stats.1985, c. 1075, p ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.1. Definitions

As used in this part, the following terms mean:

(a) "Freestanding cardiac catheterization" means the performance of coronary angiography or cardiac catheterization, or both in a laboratory separate from a general acute care hospital. For the purpose of this part, at least one pilot site shall include the use of state-of-the-art digital electronic computer technology with simultaneous multiplane dynamic imaging capabilities and 1024 × 1024 resolution and 512 × 512 at 30 FPS or comparable technology.

(b) "Freestanding cardiac catheterization laboratory" means a laboratory, separate from a general acute care hospital, where outpatient cardiac catheterization procedures may be performed pursuant to this part.

(c) "Office" means the Office of Statewide Health Planning and Development.

(d) "State department" means the State Department of Health Services.

(e) "Pediatric cardiac surgery service" means a program of a general acute care hospital which has the capability of performing cardiac catheterization and cardiac surgery, as defined in this section, for the diagnosis and treatment of congenital defects in children. Cardiac catheterization for pediatric patients shall be performed only in a general acute care hospital that has the capability to perform cardiac surgery on pediatric patients and shall not be performed in freestanding cardiac catheterization laboratories designated pursuant to this part. For purposes of this section, "pediatric patient" means a patient who, as of the date of the medical procedure, has not reached his or her 18th birthday.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation. Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.2. Establishment and administration of pilot program

(a) The Office of Statewide Health Planning and Development may establish and administer a pilot program to test the safety and cost effectiveness of performing cardiac catheterization in freestanding cardiac catheterization laboratories. The office may approve up to seven freestanding cardiac catheterization laboratories for inclusion under the pilot program.

(b) No project approved pursuant to this section may be in the same primary market area, as determined by the office, as another project approved by the office as a cardiac catheterization laboratory pilot project.

(Added by Stats.1985, c. 1074, p. ——, § 1. Amended by Stats.1986, c. 1068, § 1, urgency, eff. Sept. 24, 1986.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.3. Applications: forms

Persons who wish to establish freestanding cardiac catheterization laboratories shall make application to the office for inclusion in the pilot program on forms provided by the office. Applicants shall submit a separate application for each proposed pilot site. The forms shall require the information determined to be needed by the office. At a minimum, the forms shall require the effective date for initiating pilot project services, the general service area and a description of the population to be served, a detailed description of the services to be provided, a description of backup emergency services, the availability of comprehensive care, and the qualifications of the general acute care hospital providing the emergency treatment, curricula vitae for the laboratory directors and key staff, and internal quality assurance criteria and procedures.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.4. Direction of laboratories; qualifications of physicians and surgeons

Each freestanding cardiac catheterization laboratory shall be under the direction of a physician and surgeon with demonstrated expertise in performing cardiac catheterization.

All physicians and surgeons performing cardiac catheterization in freestanding laboratories shall be board-eligible or board-certified by the American Board of Internal Medicine, with subspecialty certification in cardiovascular disease, or board-eligible or board-certified by the American Board of Radiology, with specialty certification in diagnostic radiology and demonstrated competence in performing cardiac catheterization.

Other desirable qualifications include membership in the Society of Cardiovascular and Interventional Radiology, the North American Society of Cardiac Radiology, the Society for Cardiac Angiography, or similar equivalent expertise.

The office shall determine whether or not an applicant's qualifications meet the requirements of this section. The office shall have the discretion to approve equivalent qualifications in consultation with the technical advisory committee.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.5. Statistical data and patient information; confidentiality; suspension or withdrawal of approval

As a condition of participation in the pilot program, each applicant shall agree to provide the statistical data and patient information that the office deems necessary for effective evaluation, at such times as the office requires. It is the intent of the Legislature that the office shall develop procedures to assure the confidentiality of patient information, and shall only disclose patient information, including names, as is necessary pursuant to this part or any other law.

The office may suspend or withdraw approval of pilot projects with notice but without hearing if the office determines that patient safety is or may be jeopardized. A pilot project shall have the right to appeal a suspension to the director of the office, but shall not resume performing freestanding cardiac catheterization services pending a favorable outcome of the appeal.

The office may suspend or withdraw approval of pilot projects for reasons other than patient safety, including any violations of the agreement to participate in the pilot program, but in those instances, the office shall give notice to the pilot project director and afford an opportunity to be heard.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.6. Technical advisory committee; members; conflict of interest; reimbursement for expenses; duties

The office shall appoint a technical advisory committee to advise the office on the administration of this part. The technical advisory committee shall include, but not necessarily be limited to, a representative of the state department and at least four physicians and surgeons who have specialized training and experience in the field of cardiovascular disease or diagnostic radiology, with training in cardiovascular disease. These physicians and surgeons shall have affiliation with major teaching institutions.

A member of the Technical Advisory Committee shall not be an officer of or a director of any freestanding cardiac catheterization laboratory or have any significant beneficial or ownership interest in any freestanding cardiac catheterization laboratory designated pursuant to this part. The office shall not consider the application of a person or business entity wishing to establish a freestanding cardiac catheterization laboratory if a member of the technical advisory staff will be the laboratory director or be on the staff of or be an officer of or director of or have a beneficial or ownership interest in the proposed freestanding cardiac catheterization laboratory.

Members of the technical advisory committee shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the committee.

Duties of the committee shall include, but not be limited to, advising the office on standards and criteria for approving pilot projects, advising the office on the implementation and ongoing monitoring of the pilot program, and advising the office on the evaluation of the results of the pilot program.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.7. Report to legislature

The office shall submit a report to the Legislature on the progress of the pilot program on or before July 1, 1988. The report shall include, but not be limited to, an evaluation of the cost, safety, and quality of care and quality of studies produced by the pilot projects. The report shall also include a recommendation as to whether freestanding cardiac catheterization should be continued, and if so, under what conditions. The report shall include a comparison of procedures in freestanding cardiac catheterization laboratories with those performed in general acute care hospitals.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.8. Requirements; protocols; informed consent

The office shall establish, at a minimum, spatial, staffing, and equipment requirements for laboratories participating in the pilot program.

Protocols for the performance of freestanding cardiac catheterization procedures on an outpatient basis shall be established by the office. The protocols shall include, but not be limited to, criteria for the selection of patients or exclusion of patients from the performance of freestanding cardiac catheterization, equipment, and procedures necessary for the stabilization of patients in emergency situations prior to transfer, and criteria for patient transfer arrangements in emergency situations, which shall be in accordance with the standards established by the Emergency Medical Services Authority. No other health facility or clinic licensing or certification requirements shall be required for the performance of freestanding cardiac catheterization. The office may consult with the state department as necessary. The office may contract for specialized medical consultation, or other personnel or other services as necessary for the effective implementation of this part.

Each cardiac catheterization laboratory shall assure the office that patients examined by this program have given written informed consent.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.9. Regulations

The regulations the office adopts to implement this part shall be adopted as emergency regulations in accordance with Section 11346.1 of the Government Code, except that the regulations shall be exempt from the requirements of subdivisions (e), (f), and (g) of that section. The regulations shall be deemed to be an emergency for the purposes of Section 11346.1 of the Government Code and shall remain in effect until January 1, 1989, unless amended or repealed by the office.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.10. Fee

The office may charge participants in the pilot program a reasonable fee, not to exceed the cost of administering this part.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

§ 444.11. Duration of part

This part shall remain in effect only until January 1, 1989, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1989, deletes or extends that date.

(Added by Stats.1985, c. 1074, p. ——, § 1.)

1985 Legislation.

Addition of this section by § 1 of Stats.1985, c. 1075, p. ——, failed to become operative under the provisions of § 7 of that Act.

EXHIBIT 2

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL ACCOUNTING AND REPORTING MANUAL

QUARTERLY REPORTING REQUIREMENTS

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QUARTERLY REPORTING REQUIREMENTS

PREFACE

Section 443.32 of the Health and Safety Code requires hospitals to report specified summary financial and statistical data. Quarterly financial and utilization reports must be submitted by all hospitals for each calendar quarter beginning on or after January 1, 1986. Forms will be mailed to each facility approximately two weeks after the end of each calendar quarter.

The quarterly financial and statistical report must be completed and submitted to the Office within 45 days after the end of the calendar quarter. In order to be complete, all required items must be completed in accordance with the instructions and shall conform to the uniform description of accounts contained in the Office's "Accounting and Reporting Manual for California Hospitals". Any hospital which does not file the summary financial and statistical report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, considering all extension days granted by the Office's Director.

Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

All reports must be submitted to the:

Office of Statewide Health Planning
  and Development
Health Facility Data Division
1600 - 9th Street, 4th Floor
Sacramento, CA 95814

This chapter contains a copy of the quarterly report and instructions.

QUARTERLY REPORTING REQUIREMENTS

GENERAL INSTRUCTIONS FOR COMPLETING QUARTERLY REPORTING FORM 8100

The following rules apply to completing and submitting the quarterly financial and utilization report form:

1. One copy of the quarterly reporting form prescribed by the Office must be submitted to the Office within 45 days after the close of each calendar quarter. This requirement also applies to hospitals that were closed or relocated to a new facility during the quarter. In the event the report is due on a Saturday, Sunday, or Holiday, the report may be postmarked on the next business day.

2. A reproduced copy is acceptable if legible and includes an original signature. Reports which are not legible will be returned for recopying.

3. In order to be considered complete, the report must be correctly filled out in accordance with the instructions herein and in conformance with the definitions of the account descriptions contained in the Office's "Accounting and Reporting Manual for California Hospitals".

4. All amounts shall be reported in whole dollars.

5. Any hospital which does not file the report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, taking into account any extensions granted as provided in Section 97051, Chapter 10, Title 22, California Administrative Code.

6. Partial quarter reports must be filed by hospitals which have been in operation for less than one quarter at the end of the first calendar quarter of their operation.

7. When the ownership of the hospital changes during the calendar quarter, a quarterly report must be filed with the Office by the former owners for the period of their ownership, and a report filed by the new owners for their first and subsequent calendar quarters. The first calendar quarter may be less than three months. Both reports must be submitted within 45 days after the end of the calendar quarter in which the ownership change occurred.

8. Since all quarterly reports are for calendar quarters, changes in fiscal years will not impact quarterly reporting. Facilities using a 13-period accounting cycle must obtain prior approval from the Office before submitting data based on these accounting periods.

QUARTERLY REPORTING REQUIREMENTS

9. No line or column descriptions are to be changed under any circumstances.

10. Revisions to prior quarterly reports should be submitted on the report form for the calendar year in which the quarter occurred. For example, a revision to the report for the second quarter of 1984 should be submitted on a 1984 quarterly report form. Indicate the quarter being revised by checking the appropriate line in column 3 for lines 10 through 14.

    If a prior year report form is not available, please photo copy the hospital's copy of the quarterly report submitted for the quarter being revised and indicate the changes in red.

11. Hospitals that receive the preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans and are operated as units of a coordinated group of health facilities under common management may provide data for lines 50, 55, 60, 65, and 66 through 85 on a group basis. However, such hospitals are encouraged to report line 50, Total Operating Expenses, for each hospital.

DETAILED INSTRUCTIONS FOR COMPLETING QUARTERLY REPORTING FORM 8200

1. Enter in item 1 the name under which the hospital is doing business. This may be the hospital's legal name.

2. Enter the State Facility Number in item 2. This nine digit number appears on the license issued by California Department of Health Services.

3. In items 3, 4, and 5 enter the hospital street address, city and zip code, respectively.

4. Enter in items 6 and 7 the name and complete phone number of the person who completed the report.

5. The reporting form has been designed for full or partial calendar quarters and for either original or revised data.

    If the report is for a full calendar quarter, check the appropriate line in column 2 or column 3 for the quarter being reported. Column 2 is to be checked if the report is an original report and column 3 is to be checked if the report is a revised report. Revised reports to reflect changes resulting from audited financial statements may be filed within four months of the close of the hospital's fiscal year.

QUARTERLY REPORTING REQUIREMENTS

If the report is for less than a full calendar quarter, enter the beginning date of the reporting period on line 14, column 1, and the ending date of the reporting period on line 15, column 1, and check column 2 or column 3 as appropriate.

6. For lines 20 through 95, enter the appropriate data pertaining to the quarter being reported.

7. Enter on line 20 the number of licensed beds stated on the facility license as of the last day of the reporting period.

8. Enter on line 25 the daily average complement of beds (excluding bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Do not include beds in nursing units converted to uses other than inpatient overnight accomodations which cannot be placed back into service within 24 hours. The number of available beds may be and often is less than the number licensed. On rare occasions, such as pending license application for a new inpatient service, the number of available beds may exceed the licensed beds.

   NOTE: The definition of "Available Beds" differs from that used in the Office's annual hospital disclosure report.

9. Enter on line 30 the daily average complement of beds fully staffed during the quarter. Staffed beds are those beds set up, staffed, equipped and in all respects ready for use by patients remaining in the hospital overnight. Hospitals typically staff for those beds currently occupied by inpatients, plus an increment for unanticipated admissions.

   NOTE: The number of staffed beds may be less than the number of available beds. It can never be greater.

10. Enter on lines 31, 32, and 34 by payor (Medicare, Medi-Cal, and Other, respectively) the number of discharges from all Daily Hospital Service cost centers during the reporting period, excluding newborns and including deaths. Enter on line 35 the sum of lines 31, 32, and 34. This is the total number of discharges from the hospital including transfers or discharges from the acute care section to the residential care section of the hospital.

11. On lines 36, 37, and 39 enter the total number of census patient days by payor, excluding newborns. Count the day of admission but not the day of discharge as a patient day. Count as one day, each patient admitted and discharged on the same day. Enter on line 40 the sum of lines 36, 37, and 39.

QUARTERLY REPORTING REQUIREMENTS

12. Enter on lines 41, 42, and 44 the total number of outpatient visits by payor. Enter the sum of lines 41, 42, and 44 on line 45. Outpatient visits are the sum of emergency room outpatient visits, outpatient clinic visits, referred ancillary service visits, home health contacts, and day care days for the reporting period.

    An emergency room outpatient visit is defined as medical attention given an emergency outpatient who is treated and released. Do not include emergency patients who are treated and admitted as inpatients. Visits made by emergency outpatients to ancillary cost centers such as laboratory or radiology are not to be included.

    Count each visit to a separately organized clinic unit by a clinic outpatient as one visit. Visits made by clinic outpatients to ancillary cost centers such as laboratory or radiology are not to be included.

    A referred ancillary visit is defined as an appearance of a private referred outpatient to each ancillary service cost center regardless of the number of units of service or treatments that the patient received.

    Home health contacts are defined as the number of home health patients visited at their place of residence by representatives of the hospital's home health program.

    Day care days are defined as the count of full and partial days patients in organized partial day or night care programs spent in the hospital. Day care includes outpatient surgeries, day and night care psychiatric programs, and renal dialysis treatments.

13. Enter Total Operating Expenses on line 50. This amount consists of all operating expenses incurred by the hospital accrued to the end of the reporting period. If the physicians' professional component (all amounts paid to hospital-based physicians and interns and residents for patient care) is recorded as an expense, it should be included in this amount. Non-operating expenses and provisions for income taxes are excluded.

14. Line 55 is an optional reporting item. However, hospitals are encouraged to report this amount as it will allow a better indication of the change in Total Operating Expenses. Enter the physicians' professional component expenses of the physicians' total compensation. This includes all amounts paid or to be paid to hospital-based physicians and interns and residents for patient care and recorded as an expense of the hospital.

QUARTERLY REPORTING REQUIREMENTS

15. Enter Gross Inpatient Revenue on line 60. This amount is the total inpatient charges at the hospital's full established rates for services rendered and goods sold to inpatients. It includes daily hospital services and inpatient ancillary services.

16. Enter Gross Outpatient Revenue on line 65. This is the total outpatient charges at the hospital's full established rates for outpatient ancillary services rendered and goods sold to outpatients.

17. Enter on lines 66 through 74 the various component amounts of the hospital's deductions from revenue, as defined in Section 2410.4 of the Manual, for the reporting period.

    . Enter Medicare contractual adjustments on line 66.
    . Enter Medi-Cal contracutal adjustments on line 67.
    . Enter on line 68 the provision for bad debts.
    . Enter Hill-Burton charity amount on line 69 and other charity amounts on line 70.
    . Enter on line 71 restricted donations for indigent care.
    . Enter on line 74 other deductions from revenue not specified above.
    . Enter the sum of lines 66 through 74 on line 75. This is the sum of all deductions from revenue net of gifts and subsidies for indigent care (line 71).

18. Enter Net Patient Revenue for the reporting period on lines 76, 77, and 84 by payor. Net Patient Revenue is defined as gross patient revenue minus related deductions from revenue. Enter the sum of lines 76, 77, and 84 on line 85. Total Net Patient Revenue on line 85 must equal line 60 plus line 65 minus line 75.

19. Enter the amount of Total Capital Expenditures made during the reporting period on line 90. Capital expenditures are defined as all additions to property, plant and equipment, including amounts which have the effect of increasing the capacity, efficiency, lifespan, or economy of operation of an existing capital asset. These are the expenditures recorded under the property, plant and equipment accounts of the balance sheet, and are subject to depreciation or amortization. (Amounts used for acquiring land for hospital operations must be included here although land does not depreciate.) Be sure to include all capitalized leases and construction-in-progress in addition to purchased property, plant and equipment. Do not reduce capital expenditures to reflect accrued depreciation expense or the disposal of capital assets.

QUARTERLY REPORTING REQUIREMENTS

20. Enter the amount of Fixed Assets Net of Accumulated Depreciation at the end of the reporting period on line 95. Net fixed assets include land, land improvements, buildings and improvements, leasehold improvements, and equipment, less accumulated depreciation and amortization thereon, plus construction-in-progress.

21. Enter any comments you may have on the lines provided.

22. The certification is to be completed by an authorized official of the hospital after the report has been completed. The person signing the certification should be aware of the contents of the report and that the certification is being made under penalty of perjury.

23. Mail the completed report to:

    Office of Statewide Health Planning
    and Development
    Health Facility Data Division
    1600 - 9th Street, 4th Floor
    Sacramento, CA 95814

    Telephone: (916) 323-7681

REPORTING FORM 8300

The following is a reproduction of the Quarterly Financial and Utilization Report form to be submitted by all hospitals.

HOSPITAL

QUARTERLY FINANCIAL AND UTILIZATION REPORT

OSHPD USE ONLY: 198___ 10______

Postmark Date: _____/_____/_____

1. Facility DBA (Doing Business As) Name:
2. State Facility No.:
3. Street Address:
4. City:
5. Zip Code:
6. Report Prepared By:
7. Phone: (   ) EXT

Line No.	(1) Report Period:	Report Due Date:	(2) Original	(3) Revised
			(Check One)	
10	January 1 - March 31, 1986	May 15, 1986		
11	April 1 - June 30, 1986	August 14, 1986		
12	July 1 - September 30, 1986	November 14, 1986		
13	October 1 - December 31, 1986	February 14, 1987		
14	Other (Specify: Month, Day, Year) From: ____/____/____/ To: ____/____/____/	Within 45 days of the end of the corresponding calendar quarter		

	ITEM	1986 QUARTER
20	Licensed beds (end of report period)	
25	Available beds (average for report period)	
30	Staffed beds (average for report period)	
	Discharges (excluding newborns)	/ / / / / / /
31	Medicare	
32	Medi-Cal	
34	Other	
35	Total Discharges (sum of lines 31-34)	
	Patient Days (excluding newborns)	/ / / / / / /
36	Medicare	
37	Medi-Cal	
38	Other	
40	Total Patient Days (sum of lines 36-39)	
	Outpatient Visits (ER, Clinic, Referred, Day Care, Home Health)	/ / / / / / /
41	Medicare	
42	Medi-Cal	
44	Other	
45	Total Outpatient Visits (sum of lines 41-44)	
50	Total Operating Expenses (including PPC)	$
55	Physician Professional Component Expenses **	$
60	Gross Inpatient Revenue	$
65	Gross Outpatient Revenue	$
	Deductions from Revenue	/ / / / / / /
66	Medicare Contractual Adjustments	$
67	Medi-Cal Contractual Adjustments	
68	Provision for Bad Debts	
69	Charity - Hill-Burton	
70	Charity - Other	
71	Gifts, Subsidies for Indigent Care	)
74	Other Adjustments and Allowances	
75	Total Deductions from Revenue (sum of lines 66-74)	$
	Net Patient Revenue (Gross Rev. less Ded. from Rev.)	/ / / / / / /
76	Medicare	$
77	Medi-Cal	
84	Other	
85	Total Net Patient Revenue (sum of lines 76-84)	$
90	Total Capital Expenditures	$
95	Fixed Assets Net of Accumulated Depreciation	$

Comments:

** The reporting of this item is optional.

SEE CHECKLIST ON OTHER SIDE

CERTIFICATION

I, ____________________________, hereby certify under penalty of perjury that to the best of my knowledge and information that the information reported above is true and correct.

Mail original to:

Office of Statewide Health Planning & Development
Health Facility Data Division
1600 - 9th Street, 4th Floor
Sacramento, California 95814
Telephone: (916) 323-7681

By: ____________________________

Title: ____________________________

Dated: ____________________________

QUARTERLY REPORT CHECKLIST

The Office has developed the following checklist to assist you in preparing your quarterly report. Use of this checklist may reveal data errors that you can correct before submitting your report, thus eliminating the need for Office staff to contact you with questions in these areas. Data items should be reasonable and consistent with previously filed reports. If you answer "no" to any of these questions, you should verify the appropriate data items.

_____ 1. Is licensed bed occupancy rate [line 40 ÷ (line 20 x number of days in the report period)] correct?

_____ 2. Is available bed occupancy rate [line 40 ÷ (line 25 x number of days in the report period)] correct?

_____ 3. Is staffed bed occupancy rate [line 40 ÷ (line 30 x number of days in the report period)] correct?

4. Is average length of stay by payor and by total correct?

_____ a) Medicare (line 36 ÷ line 31) _____ c) Other (line 39 ÷ line 34)
_____ b) Medi-Cal (line 37 ÷ line 32) _____ d) Total (line 40 ÷ line 35)

_____ 5. Do outpatient visits (lines 41-45) include ER visits, Clinic visits, referred ancillary visits, home health visits and day care days?

_____ 6. Do total operating expenses (line 50) include PPC and exclude non-operating expenses and income taxes?

_____ 7. Is gross inpatient revenue per patient day (line 60 ÷ line 40) correct?

_____ 8. Is gross inpatient revenue per discharge (line 60 ÷ line 35) correct?

_____ 9. Is gross outpatient revenue per visit (line 65 ÷ line 45) correct?

_____ 10. Does gross patient revenue (line 60 + 65) less deductions from revenue (line 75) equal total net patient revenue (line 85)?

_____ 11. Do capital expenditures (line 90) include only additions to property, plant and equipment, including capitalized leases and construction-in-process? Do not reduce by depreciation or disposals.

_____ 12. Do this quarter's net fixed assets (line 95) equal last quarter's net fixed assets plus this quarter's capital expenditures (line 90) less this quarter's disposals and depreciation?

If there has been any significant change in utilization, patient mix or service mix, please complete the comments section on the front of this reporting form. Detailed instructions for preparing your quarterly report are included in Section 8000 of the Manual.

RETURN TO: Office of Statewide Health
Planning and Development
Health Facility Data Division
1600 9th Street, 4th Floor
Sacramento, California 95814

AH-019

Chairman **Stark**. Thank you.

Ms. Scanlan.

STATEMENT OF CAROLYN F. SCANLAN, EXECUTIVE VICE PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE

Ms. **Scanlan**. Mr. Chairman and Mr. Moody, I am Carolyn Scanlan of the Hospital Association of New York State. Our association represents over 300 voluntary and public hospitals and health care facilities with over 73,000 beds.

We believe that responsible public policy development requires data which is timely, accurate, and consistently collected. Medicare policy decisions require the same type of reliable data.

In New York, we have been able to create a reliable and usable hospital cost data base within 8 to 9 months after the close of the cost reporting year. It takes the Health Care Financing Administration 2½ to 3 years to develop this same type of reliable, though not timely, hospital cost data base.

Since 1970, New York State hospitals have reported their costs to all third-party payers using a uniform financial report. While New York's reporting form differed and continues to differ from the Medicare form used in other States, it has been approved by the Health Care Financing Administration, and, more importantly, it provides the Medicare program with the same information as the standard Medicare report.

The question before us today is whether the Medicare cost reports, as currently designed, collected, and analyzed, are able to provide us with reliable and timely information. There are several questions we must ask ourselves about the data base.

Was the data base designed for the purposes for which we want to use it? Is the data reported in a uniform and consistent manner? Is the data timely?

The information we currently garner on the reports tells us little about how hospitals are currently responding to the prospective payment system or the effects of future changes in the prospective payment system on the delivery of medical services. We clearly need to review the data that is currently collected, discern what is the right data, and begin to collect it.

However, the mere collection of data does not always assure us of the right information. Uniformity is an important element in any data system. As we are concerned with our rush to develop the uniform cost reporting system, we must not eliminate the ability of States to implement their own cost reporting system.

We do not believe that limiting the ability to use common and uniform cost reporting systems for all payers by various States will necessarily provide us with better or more uniform information.

Uniform cost reporting and uniform cost accounting are very different. We believe that uniform cost reporting is achievable without uniform cost accounting, and we believe that the consistency of the data that can be reported and collected and analyzed under uniform cost reporting is sufficient for the kinds of public policy decisions which need to be made.

The world is changing very fast, and old data simply does not give us the information we need to make today's decisions. The question that we all face is why are we relying on 4-year-old data for making decisions for 1988 and beyond?

We believe it would be appropriate to take a moment to compare our experience in New York State with the Federal experience. To begin with, within 7 or 8 months after the close of the cost reporting year, New York State has reliable and usable hospital cost data base. As we said earlier, it takes 2 to 3½ years for the Health Care Financing Administration to create a similar data base.

It appears to us that the problem is not in the reporting of the data by the hospitals, but in the creation of the data base, the analyzing of the data, the editing of the data for it to be available. We believe that if one were to look to the New York State experience where the uniform data is certified by a certified public accountant at the time of initial submission, within 120 days of the close of the fiscal year—and as an aside I should note that the fiscal year for all hospitals in New York State is the same; it is mandated as the calendar year. And within the 120 days after the close of that calendar year the data is submitted, within 90 days it is edited and prepared as a computer base file, and that data, therefore, is ready for us within 7 months after the close of the calendar year.

We do not believe that the same fiscal year is required at the Federal level, but we do believe that the timeliness of the creation of the data base is essential. And it is that timeliness by the Federal Health Care Financing agency which we must look to in the development of a more uniform data base, more reasonable data base.

We, therefore, would recommend that a careful review of the Medicare cost report to eliminate any current reporting requirements which are not necessary and the addition of those which are required for prospective payment system be initiated immediately. We would offer our assistance and expertise from the New York State in the development and review of such an activity. We believe that the continued flexibility of States is required within any recommendation that would come forth from such a group, and we would support the continued activities in the New York State area in a uniform cost reporting for all payers.

Thank you.

[The statement of Ms. Scanlan follows:]

STATEMENT BY CAROLYN F. SCANLAN, EXECUTIVE VICE PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE ON HOSPITAL COST REPORTING

I am Carolyn F. Scanlan, Executive Vice President of the Hospital Association of New York State. I would like to thank the Committee for providing us the opportunity to testify on this important subject. Reliable and timely cost reporting is as important to New York hospitals as it is to the Federal government.

In New York, we are able to create a reliable and usable hospital cost data base within eight to nine months after the close of the cost reporting year. It takes the Health Care Financing Administration 2½ to 3 years to develop a reliable hospital cost data base.

BACKGROUND

Since 1970, New York State hospitals have reported their costs to third party payors using a uniform financial report. While New York's reporting form differed and continues to differ from the Medicare form used in other states, it has been approved by the Health Care Financing Administration and, more importantly, it provides the Medicare program with the same information as the standard Medicare reporting form.

The Statewide Planning and Research Cooperative System (SPARCS) was implemented by the New York State Department of Health in 1979, with the cooperation and initial financial support of the U.S. Department of Health and Human Services. SPARCS receives, processes, stores and analyzes inpatient data from all general hospitals in New York State. It serves as a comprehensive and integrated information network that supports and links the functions of health care resource planning, financing and surveillance of hospital services in New York State.

While meeting the informational needs of the Department of Health, SPARCS has also proven an effective management tool for the health care industry. SPARCS was designed to make use of existing data sources to the greatest extent possible to minimize duplicative reporting requirements for New York hospitals. SPARCS collects data from two sources, the discharge data as reported on computer tapes rather than on paper forms. The uniform billing form used as the uniform claim form for all third-party payors in New York State also serves as a reporting document for SPARCS.

Over the last several years, the Hospital Association of New York State has developed a number of programs to help hospitals use this data system effectively. We have helped hospitals measure utilization trends, physician performance and the cost of caring for different types of patients. In the very near future, we will be building the programs necessary to measure and more clearly define the quality of hospital care. These programs will assist hospitals in determining best practice patterns, reviewing physician practices, defining acceptable medical outcomes and managing risk.

The question before us today is whether the Medicare cost reports are able to provide us with reliable and timely information.

There are several questions we must ask about any data base: Was the data base designed for the purposes for which we want to use it? Is the data reported in a uniform and consistent manner? Is the data timely?

PURPOSE

Prior to the implementation of the Medicare Prospective Payment System in 1983, the Medicare Hospital Cost Report had one purpose—to establish interim Medicare rates of payment and, once audited, to retroactively establish final cost-based rates of payment. The Prospective Payment System eliminated cost-based reimbursement, the need to make retroactive adjustments and, in many respects, the need for the Medicare Cost Report.

Today, we are trying to use these cost reports to make decisions about how we should change the Prospective Payment System. Unfortunately, it may be the wrong data. The information we garner from these reports tells us little about hospital profits, about how hospitals are responding to changes in the Prospective Payment System or the effects of future changes in the Prospective Payment System on the delivery of medical services.

We don't need to collect more data; we need to collect the right data. Collecting the right data also means not collecting data we no longer need.

UNIFORMITY AND FLEXIBILITY

Uniformity does not mean rigidity.

Uniformity is an important element in any data system. We are concerned that in our rush to develop more uniform cost reporting, we will eliminate the ability of states to implement their own cost reporting systems. We do not believe that limiting the ability of states to use common and uniform cost reporting systems for all payors will provide us with better or more uniform data. Better and more uniform data will come from better precision in how we define and allocate the elements of hospital costs.

UNIFORM COST REPORTING VS UNIFORM COST ACCOUNTING

Good uniform cost reporting is possible without uniform cost accounting.

Uniform cost reporting and uniform cost accounting are very different. Uniform cost reporting requires every hospital to report each element of cost to the Medicare program in the same way as every other hospital. Uniform cost accounting requires every hospital to employ exactly the same accounting system—the same chart of accounts. In other words, it would require hospitals either to keep two sets of books or to budget and manage their finances in exactly the same manner as every other hospital in the country.

Uniform cost accounting is not practical. It would require a small rural hospital to use the same accounting system as a 1,200 bed academic medical center. It would require public hospitals to use the same accounting system as hospitals that are part of publicly traded corporations.

Ten years ago, both the federal government and the State of New York proposed uniform hospital accounting systems. Neither has yet required hospitals to adhere to a uniform chart of accounts. We believe that both the State of New York and the Health Care Financing Administration have come to the conclusion that good uniform cost reporting is possible without uniform accounting.

TIMELINESS

The world is changing very fast and old data simply does not give us the information we need to make today's decisions. Nonetheless, we seem determined to make decisions about the future of the Prospective Payment System using data and information that no longer fit.

Using 1984 data to project hospital profit margins in 1988 is, at best, a crude measure and, at worst, unethical.

Using 1984 data to project hospital capital costs in 1989 is, at best, misleading and, at worst, a distortion.

The question is why are we relying on hospital costs reports that are three or four years old? The answer lies not in how or how often hospitals file their cost reports but with the Health Care Financing Administration.

It may be appropriate to compare our experience in New York State with the federal experience. To begin, within seven or eight months after the close of the cost reporting year, New York State has a reliable and usable hospital cost data base. It takes the federal Health Care Financing Administration 2½ to 3 years to develop a reliable and usable hospital cost data base.

There are several notable differences between how New York State collects hospital cost reports and prepares its hospital cost data base and how the federal government does it.

First, the Medicare program requires hospitals to submit unaudited, uncertified cost reports to the Medicare fiscal intermediary within 90 days of the close of the fiscal year. New York State requires hospitals to submit cost reports certified by a certified public accountant (CPA) to the state fiscal intermediary within 120 days of the close of the fiscal year. It is interesting to note that in New York, Blue Cross is both the Medicare fiscal intermediary and a state fiscal intermediary for the purpose of collecting and editing the hospital cost reports.

Second, it takes the Medicare fiscal intermediary at least 180 days to edit and enter the data onto a computer. In contrast, the state's fiscal intermediary must complete its edits and prepare a computer file within 90 days.

Third, the Federal Health Care Financing Administration spends approximately six months re-editing and reformatting the data they receive from their fiscal intermediaries. New York receives reliable and usable hospital cost data upon which to make decisions.

Fourth, the Health Care Financing Administration is unable to use its hospital cost data base until it is audited. This delays using the data base by at least one year. New York state is able to use its data base immediately because it receives certified cost reports. It is also important to note that while New York States does audit hospital costs, the audit findings are, in general, very minor.

This comparison leads us to believe that we can have a reliable national Medicare data base in a timely fashion. The answer does not lie in requiring hospitals to report more often or more data, but in altering the methods used by the administrative agencies in preparing and developing this data base.

We recommend:

1. A careful review of the Medicare cost report, eliminating any reporting requirements that are no longer relevant to today's needs.
2. A cautious approach to asking hospitals to report new data. We must remember that new reporting requirements are costly and detract from a hospital's patient care abilities.
3. A study of the strengths and weaknesses of the current hospital cost data base.
4. Continued flexibility for states with uniform cost reporting for all payors within the state.
5. Changing the way in which the Health Care Financing Administration collects and prepares the hospital cost data base.

Thank you.

Chairman **STARK**. Thank you.

Mr. Kovener. Did I pronounce that right?

Mr. **Kovener**. It is going to be Mr. Clarke, but Mr. Kovener is right.

Chairman **Stark**. Mr. Kovener is right, but Mr. Clarke. Pinch-hitting for Mr. Kovener?

Mr. **Clarke**. We are working together.

Chairman **Stark**. All right. Go ahead, then.

STATEMENT OF RICHARD L. CLARKE, PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, ACCOMPANIED BY RONALD R. KOVENER, VICE PRESIDENT

Mr. **Clarke**. Thank you, Mr. Chairman, Mr. Moody.

The Healthcare Financial Management Association, or HFMA, is pleased to have this opportunity to speak before this group and express views related to fiscal reporting by hospitals. My name is Dick Clarke, not from the American Bandstand, but, rather, the president of the association. With me is Ronald Kovener from our Washington office.

HFMA is a professional membership association of over 25,000 individuals who have primary responsibility for the maintenance and the accumulation of statistical and financial records. As such, that group is very involved in this particular issue.

HFMA is in total agreement that Congress and the administration must have timely, accurate, and meaningful information for decisions. First, I will enumerate some general considerations about financial reporting, detail some concerns about the Medicare cost report, and then describe how to meet the data needs.

The basic principle of financial reporting is to identify the information that is needed, and then design a report that fills those needs. Knowing everything about everything is not a realistic goal.

Narrowly defined data is subject to more error and misinterpretation than more broad-based data. Succinct data that is designed to meet a need is more useful than data that is voluminous or designed in a general way.

The Medicare cost report is a uniform financial report. This report is one of the most burdensome of reports required by the Federal Government, but the data in the report is distorted by definition designed to minimize payment for services. Therefore, the information included in that particular report is ill suited for public policy decisions by Congress.

The current procedures for processing the Medicare cost report delays the availability of the data to an unrealistic extent.

HFMA recommends that congressional needs be met through a combination of data from a redesigned and simplified Medicare cost report, and from industry data such as that which is available from the American Hospital Association or HFMA.

The Medicare cost report must be entirely redesigned and definitions revised to conform with generally accepted accounting principles and sound cost allocation techniques. The data compiled in the Medicare cost report should be a representation of costs that we all can embrace as being accurate and reasonable. Current Medicare rules prevent achieving that objective.

The refocusing of the cost report is feasible under current circumstances. Medicare payments for the most part are no longer made based on the cost report information. Therefore, distortions built into the cost report, originally designed to reduce Medicare payment to hospitals, can be eliminated.

The amount of data that Medicare collects and abstracts for analysis can also be substantially reduced. Attached to my written statement is information related to the HFMA Financial Analysis Service. HFMA is able to prepare this service using only 32 elements of data from audited financial statements. This is in sharp contrast to the 600 or 700 data elements that are abstracted by HCFA from the Medicare cost report. The data HCFA analyzes is not focused toward decision usefulness and, accordingly, is needlessly complex and costly.

The timeliness of compiling data can also be significantly improved. For example, it should be possible on June 1st of 1987 to have information about a hospital's current financial information for a year's ending in 1986, only 5 months after the year end.

This Medicare information should be regularly compared to industry data compiled by AHA and HFMA. To the extent that there are differences, those differences should be looked at.

In conclusion, HFMA agrees that data for decisions is essential. A great deal of data is currently available. Unnecessary data and the inappropriate focus of data currently collected by Medicare can and should be eliminated. There are a number of options for improving the timeliness of data. Financial managers and HFMA have demonstrated an interest, willingness, and competence to meet the data requirements, and should continue to be involved in the process.

Thank you.

[The statement of Mr. Clarke follows:]

Statement of the
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
Before the
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
Hearings on
Fiscal Year 1988 Budget Reconciliation Issues
Related to the Medicare Program --
FINANCIAL REPORTING
June 1, 1987

SUMMARY

- We agree that Congress and the Administration must have timely, accurate, and meaningful information for decisions.

- Uniform reports are already required. We need to make this data more useful rather than add to reporting burden.

- The first step in deciding what to report is to decide what use the data will serve.

- Extensive data is not required for analysis and decisions.

- The Medicare cost report can be much more useful and less burdensome if

  -- the special rules and distortions are eliminated
  -- the amount of data required to be reported is reduced
  -- the available data is compiled and reported more promptly

- The industry is willing to cooperate, but resists needless or ill conceived additions to already significant reporting burden.

The Healthcare Financial Management Association (HFMA) is pleased to have this opportunity to present views concerning financial reporting by hospitals. I am Dick Clarke, President of the Association. With me is Ronald Kovener, our Vice President, located in our Washington office. Prior to joining HFMA's staff, I was chief financial officer of Swedish Medical Center in Denver, Colorado. Mr. Kovener was chief financial officer of Bethesda Institutions in Cincinnati, Ohio prior to joining HFMA's staff. Thus, we have intimate knowledge of the record keeping and reporting operations of hospitals.

ABOUT HFMA

The Healthcare Financial Management Association (HFMA) is a professional membership association composed of over 25,000 individuals in 75 chapters who share an interest in the financial management of hospitals and other healthcare institutions. These are the individuals with primary responsibility for maintenance of the financial and statistical records and preparation of the financial reports by hospitals and other institutional healthcare providers across the country.

One of HFMA's ongoing study groups is known as the Principles and Practices Board (P&P Board). This board, consisting of 12 individuals with outstanding qualifications and national stature, is charged with formulating positions on issues relating to accounting and financial management principles and practices. The first statement issued by this board, in April 1977, dealt with "Uniform Accounting and Uniform Reporting in Hospitals." A copy of this statement is attached to our written testimony. The board's conclusions, reached just over 10 years ago, are very relevant to your concerns today.

These P&P Board conclusions were also influential in the late 1970s as Congress considered and rejected a proposal for a uniform accounting and reporting system, known as the system for hospital uniform reporting (SHUR) or the annual hospital report (AHR).

More recently, HFMA's Principles and Practices Board has concluded that all accounting and reporting by institutional healthcare providers should be guided by generally accepted accounting principles. There should be consistency among financial reports of institutional healthcare providers of all ownership types.

HFMA operates the Financial Analysis Service (FAS) which provides each subscriber hospital with an annual report of its financial performance compared to other providers in our database. Financial performance is measured in terms of 29 ratios in five major categories -- profitability, liquidity, capital structure, activity, and other. The data is obtained from audited financial reports and the data compilation and analysis is supervised by Dr. William Cleverley of Ohio State University. The table of contents of this report, which details its ratios, tables, and analysis, is attached to the written copy of our testimony. Annually we publish the Hospital Industry Analysis report based on our FAS data.

During late 1986 HFMA undertook a survey to collect current financial information, including information about profits from patient care services and services to Medicare beneficiaries. A copy of the survey report is attached to the written copy of our testimony.

GENERAL CONSIDERATIONS

HFMA is in total agreement that Congress and the administration must have timely, accurate, and meaningful information for decisions.

A basic principal of financial reporting is to identify the information that is needed and to design a report that meets those needs. Knowing everything about everything is not a realistic goal.

Obtaining, compiling, reporting, aggregating, and interpreting data is costly. The variety of operating circumstances of healthcare organizations and units influence reported data so that demographic and statistical information must accompany reported financial results.

Narrowly defined data is subject to more error and misinterpretation than more general information. For example, cost of patient service is more accurate than differentiating inpatient from outpatient cost. Similarly, cost of serving Medicare beneficiaries or any other patient group is less precise than the cost of serving all patients. The cost of determining a specific lab test is very difficult to measure precisely. Succinct data that is provided to meet a defined need is much more accurate than voluminous detailed data that is not verified and seems to fill no useful purpose.

Confidentiality of individual institutional financial information must be considered.

Financial information must meet the needs of many users. The government's demands must not interfere with, delay, or add significantly to the cost of meeting needs of other users, including the needs of management.

Finally, consistent reporting over time enhances the usefulness of data and minimizes the cost of compiling and reporting data.

UNIFORM REPORTS ALREADY EXIST

Medicare Cost Reports

The Medicare cost report is a uniform hospital financial report. This report is one of the most burdensome of all reports required by government. The data in the report is distorted by definitions designed to minimize payment for services. Therefore, the information included in the report is ill suited to the public policy deliberations of the Congress. The current procedures for processing the Medicare cost report delays the availability of this information to an unrealistic extent.

To illustrate the reporting burden which the Medicare cost report represents, one of our members reports that their 1986 cost report is almost 250 pages long, in contrast to the 1983 cost report which was only 70 pages long. The 250 pages of documentation include the cost report schedules, the cost report submission check list, and HCFA Form 339. In addition, this member was required to submit a large cardboard box full of additional data, including

- Approximately 300 physician effort reports
- Working trial balances
- All certificates of need approved during the year
- Financial statements
- All supporting workpapers and reconciliation schedules to the trial balance
- Three additional copies of the cost report
- All supporting schedules and workpapers for bad debts
- The intensive care unit policy manuals and floor plans for the ICUs

This is an unrealistic level of reporting burden.

Some of the ways in which the current Medicare definitions distort the accuracy and usefulness of information include the treatment of labor room days and the apportionment of malpractice cost. These have been extremely longstanding issues of concern and virtually every court that has been called upon to examine the Medicare handling of these issues has concluded that Medicare's treatment is illogical and inaccurate. Nonetheless, these distortions persist to this day. There are many other ways the Medicare cost report does not yield information which we in the industry would agree is accurately representative of the cost of serving Medicare patients, including:

> It is generally believed that serving elderly patients is more costly than serving the typical patient. The Medicare cost report determines only the cost of the average patient without considering the special characteristics of the Medicare group.
>
> Medicare pays no share of the cost of serving charity patients.
>
> Medicare pays only a share of cost incurred exclusively for Medicare's benefit such as the cost of preparing the Medicare cost report or making copies for a PRO.
>
> Arbitrary rules often control the allocation of cost, such as between a hospital and an attached nursing

home. These arbitrary rules yield inappropriate results.

Medicare fails to recognize the extra costs incurred in special care units other than intensive care units.

Medicare makes no compensation for the use of land. Medicare makes no contribution to growth in working capital. Medicare makes no provision for return to owners and does not recognize other costs of servicing equity capital. Medicare does not share in investments which hospitals make in such cost saving initiatives as shared laundries or captive insurance companies.

There are artificial limits on recognition of certain costs even though it is essential to incur costs or costs higher than the limits. This includes limits on compensation for hospital-based physicians, therapists, and administrators. There are unrealistic limits on amounts paid for individual purchases or items acquired from related organizations. Telephone and television costs are not recognized. Medicare limits its recognition of bad debts. Cost of offsite programs to train nurses and other workers are not paid.

The cumulative effect of these and other distortions makes the data in the Medicare cost report very inaccurate from a public policy standpoint.

Hospitals are supposed to submit their Medicare cost report 90 days after their fiscal year. Considering the extensive amount of detail that is required, this is a very difficult requirement, but one which most are able to fulfill. As far as we can tell, Medicare intermediaries do almost nothing with this information for the next 90 day period at which time it is provided to the HCFA central office. It then seems to lay in a hold file for many months until all hospitals fiscal years in an entire 12 month period have ended and their cost reports have been filed. This long delay in processing the reports that are available seems unnecessary.

American Hospital Association Data

As the primary trade association in the hospital industry, the American Hospital Association (AHA) devotes considerable resources to compiling industry data. The AHA publishes its annual directory of hospitals and its annual survey of hospital statistics. Similar data has been collected for many years, so excellent trend information is available. HFMA works with AHA to identify ways to improve the information and the way in which it is collected which is a continuous evolutionary process.

In addition, the American Hospital Association collects data on an ongoing basis from a panel of hospitals that are representative of the industry. This data can be more current than the annual compilation.

HFMA Data

As noted previously, HFMA operates a Financial Analysis Service. This database includes information from subscribers primarily and is not necessarily a statistically valid representation of the industry but the 8,562 years of data in the database makes it extremely useful. For example, investment bankers find this data invaluable in making their decisions about the credit worthiness of hospitals. The 29 ratios and extensive tables, charts, and analysis in the annual Hospital Industry Analysis report is derived from only 32 data elements extracted from the hospitals' audited financial statements. These data elements are abstracted by our contractor with very minor reporting burden by the hospital. A wealth of very useful information is available as a result.

HFMA's recent effort to collect current financial information was conducted at the year-end holiday season and we requested the data in a very short response time. Nonetheless we got 950 responses evidencing significant industry interest in assuring that good current financial information is available. This HFMA effort was unique in its collection of data about the current fiscal year and the hospitals' planned activities for next year. This was not a theoretical projection of the future, but a compilation of what our members are really planning as they respond to ever changing circumstances. We also asked for data from hospitals' cost accounting systems. Hospitals attention to cost accounting is improving and more reliable data is increasingly available.

RECOMMENDATIONS

Congressional needs should be met from a combination of data from a redesigned Medicare cost report and from industry data that can be provided by the American Hospital Association and supplemented by information from HFMA.

The Medicare cost report must be entirely redesigned and the definitions revised to conform to generally accepted accounting principles and sound cost allocation concepts. The data compiled in the Medicare cost report should be a representation of costs which the fiscal manager can embrace as being accurate. Current Medicare rules prevent achieving that objective.

This refocusing of the cost report is feasible under current circumstances. Medicare payments for the most part are no longer made on the basis of Medicare cost report information. Therefore, the distortions built into the cost report, designed to reduce Medicare payment to hospitals, can be eliminated. To the extent that unique Medicare information is required, it should be calculated after the determination of the cost of serving Medicare beneficiaries rather than distorting the determination of that cost as is presently done.

The amount of data which Medicare collects and abstracts for analysis can also be substantially reduced. For example, one of our members in the home office of a national chain indicates that their management decisions are made on the basis of only 40 elements of information abstracted from the financial report of each operating unit. This is quite similar to the extensive analysis which HFMA is able to accomplish in its Financial Analysis Service with only 32 elements of information. This is in sharp contrast to the six or seven hundred elements of information that are abstracted and analyzed by HCFA from the Medicare cost report. The data HCFA analyzes is not focused toward decision usefulness and accordingly is needlessly complex and costly.

The timeliness of compiling data can also be significantly improved. It should be possible, for example, for HCFA to abstract selected data elements from submitted cost reports within 30 days after those cost reports are received. HCFA should be able to compile and issue a comprehensive report of information about hospitals' financial condition within another 30 days. This report, issued each quarter, would include the information from all hospitals with fiscal years ending during the preceding 12 months. Each quarter, data from 1/4 of the hospitals would be updated with their new annual financial information. It should be possible on June 1 of 1987 to have such a report for all hospital fiscal years ending during 1986 -- only five months after the end of the most recently completed fiscal year in the analysis.

This Medicare information should be regularly compared to the industry data compiled by the American Hospital Association and HFMA. To the extent that there are significant differences, special studies and analyses should be undertaken to identify the reasons for the differences. Minor differences can always be expected in such a massive data accumulation process, but, these differences are not usually statistically significant.

To the extent that information from the Medicare cost report and from industry data needs to be augmented, periodic special surveys can be conducted among a scientifically random sample of hospitals. Such special analysis probably should not be done more than once a year and should be limited to not more than 20 data elements. Healthcare financial managers should be a part of any task force to select the elements and to design the reports and analyses.

CONCLUSION

HFMA agrees that data for decisions is essential. A great deal of data is already available. Unnecessary data and the inappropriate focus of data currently collected by Medicare can and should be eliminated. There are a number of options for improving timeliness of data. Financial managers have demonstrated their interest, willingness, and competence to meet data requirements and should continue to be involved in this process.

HFMA Principles and Practices Board Statement 1

uniform accounting and uniform reporting in hospitals

background

The first set of requirements an accounting system must meet are those of management. Any system which meets those needs may be considered totally adequate, provided no external requirements are introduced. However, when an external influence such as the accounting profession establishes principles upon which external reporting is to be based (generally accepted accounting principles) a substantial factor is added to the accounting and reporting requirements of the entity. Not only must management needs be met but the accounting system must also provide information in accordance with the generally accepted accounting principles.

This additional set of requirements should provide a structure for accounting and reporting in such a way that external understanding of financial reports is enhanced while the flexibility needed to meet management information needs is preserved. These new requirements, however, do not automatically provide uniformity, for two major reasons: first, there are alternatives provided within acceptable principles; and second, two entities with the same general nature will, nonetheless, have different forms of organization, managerial structures and programs. Therefore, substantial and significant differences in accounting and reporting may exist, even when the requirements of generally accepted accounting principles are met. In most cases, these differences are absolutely necessary so that a fair presentation of the financial position and results of operations can be made for an individual entity.

Another level of complexity in accounting and reporting requirements for hospitals is added by some organizations (often referred to as third party payers) which pay for hospital services on behalf of certain classes of patients. These organizations require accounting information which specifically applies to those services. Within the framework of the requirements discussed earlier, hospitals have adapted their accounting systems to meet these further external requirements.

When considering the type, size, programs, level of care and many other factors, hospital dissimilarities are extensive. The over 7,000 hospitals in this country vary by ownership (investor-owned, not-for-profit), by sponsorship (religious, community and governmental), by services rendered (medical, surgical, obstetrical, therapeutic, rehabilitative, etc.), by specialization (children's, cancer, psychiatric, etc.), by organizational structure (here the examples are infinite) and other factors too numerous to mention.

Some payers, in an attempt to simplify or solve the complexities of establishing a uniform and equitable basis of paying for services rendered in these institutions, are seeking uniformity of accounting and reporting. Advocates of uniform accounting believe that it would simplify the administration of payment and relegate auditing of the submitted information to the level of footing, cross-footing, comparing line items with those of other hospitals and drawing conclusions as to the reasonableness of the results.

discussion

There appear to be several major misconceptions about the imposition of uniform accounting on hospitals.

There is a belief by some that a single uniform accounting system can be developed that will meet all needs of the institution, including managerial control, budgetary control and preparation, external financial reporting and external cost reporting. As stated in the background, the significant dissimilarities of hospitals preclude using a single uniform accounting system to meet all of these needs, without substantial adaptation through adjusting entries, subsidiary records and reconciliations. Examples of dissimilarities include nursing personnel performing functions which may be performed in other hospitals by housekeeping personnel; charging individual patients for medical supplies which in other hospitals may be included in the daily services charge, or including the purchasing and receiving function in the fiscal responsibility cost center while others may include this responsibility in a separate responsibility cost center.

Some believe that uniform accounting will allow meaningful comparison of one hospital with another. While broad comparisons may be attainable, artificially forcing the accounting systems of hospitals into a single mold would yield uniform numbers which could be highly misleading for comparison. At the extreme, comparing nursing costs in a hospital that only served terminally ill cancer patients with such costs in a hospital that served usual medical-surgical patients, could lead to the conclusion that the personnel in the cancer hospital were highly inefficient. Even comparing hospitals providing similar patient services could be misleading if they had different labor contracts. Therefore, assuming uniform accounting in all hospitals was attainable, use of the results without extensively evaluating many other factors could lead to distorted conclusions.

Informed opinion supports the contention that a mandatory system of uniform accounting and reporting for hospitals is not desirable. As long ago as 1932, a special AICPA committee's report to the Committee on Stock List of the New York Stock Exchange concluded, "The arguments against any attempt to apply this alternative [to have a competent authority select a detailed set of rules from the body of acceptable accounting methods] to industrial corporations generally are, however, overwhelming."

Citing the Accounting Principles Board's Opinion Number 4, Paul Grady, author of *Accounting Research Study No. 7* (AICPA, 1965) concludes, "Thus, members of the Board, in common with most experienced accountants, recognize that diversity in accounting among independent business entities is a basic fact of life. There is a minority view which urges uniformity in accounting as the panacea for all accounting and reporting deficiencies. The following pertinent factors indicate the unreliability of such suggestions and expectations:

1. Judgment and estimates play a substantial role in accounting on an accrual basis.

2. Each business entity must follow generally accepted accounting principles; ... however, ... there are ... numerous alternative methods of applying such principles.

3. The attainment of a substantial degree of uniformity would require the preparation and adoption of a comprehensive manual prescribing a uniform code of accounts, with full directions as to the items to be charged and credited to each account.

4. It is obvious that no single manual of instructions would fit the needs of all industry. Therefore, the broadest possible approach would be to prepare suggested uniform systems for each type of industry. Such systems have been developed for certain industries, but most of the companies in such industries find it necessary to develop their own system to fulfill better their particular requirements for management information and control.

5. Even in those industries ... where the companies follow prescribed uniform systems, diversity in accounting is not and cannot be eliminated."

A similar opinion has been expressed in the APB *Accounting Principles:* "Although uniformity is a worthwhile goal, it should not be pursued to the exclusion of other benefits. Changes of emphasis and objectives as well as changes in conditions under which business operates have led, and doubtless will continue to lead, to the adoption of new accounting procedures. Consequently diversity of practice may continue as new practices are adopted before old ones are completely discarded."

definitions

The preferred definition of the word "uniform" in Webster's *New Collegiate Dictionary* is, "having always the same form, manner, or degree; not varying or variable." The term "accounting" is defined in the same source as "a system of recording and summarizing business and financial transactions in books and analyzing, verifying and reporting the results." Further definition of "accounting" is in the Committee on

Terminology of the American Institute of Certified Public Accountants' *Accounting Terminology Bulletin No. 1:* "Accounting is the art of recording, classifying, and summarizing in a significant manner and in terms of money, transactions and events which are, in part at least, of a financial character and interpreting the results thereof."

Accounting Research Study No. 7 of the AICPA expanded this definition as follows: "Accounting is the body of knowledge and functions concerned with systematic originating, authenticating, recording, classifying, processing, summarizing, analyzing, interpreting, and supplying of dependable and significant information covering transactions and events which are, in part at least, of a financial character, required for the management and operation of an entity and for the reports that have to be submitted thereon to meet fiduciary and other responsibilities."

Webster's defines "system" as:

"1. A regularly interacting or interdependent group of items forming a unified whole.

2. An organized set of doctrines, ideas, or principles usually intended to explain the arrangement or working of a systematic whole.

3. An organized or established procedure.

4. A harmonious arrangement of pattern."

Webster's defines "mandate" as:

"1. An authoritative command such as a formal order from a superior court or official to an inferior one.

2. An authorization to act given to a representative."

The adjective "mandatory" is defined as: "containing or constituting a command, obligatory."

In summary, a uniform system of accounting (which must, of necessity, include a system of reporting, since reporting is a part of accounting by definition) may be defined as an unvarying set of principles relating to the systematic origination, authentication, recording, classifying, processing, summarizing, analyzing, interpreting and supplying of dependable and significant information covering transactions and events, which are, in part at least, of a financial character, required for the management and operation of an entity and for the reports that have to be submitted thereon in its fiduciary and other responsibilities. It is applicable to a regularly interacting or interdependent group of items forming a unified whole.

Adding the word "obligatory" to the above defines a mandated uniform accounting system and a mandated uniform reporting system. It should be further noted that the mandated uniform accounting would be for one specific purpose and would not meet all of the reporting needs of the entity.

conclusions

Based on the above, HFMA's Principles and Practices Board concludes:

1. The primary purpose of hospital accounting is to meet the needs of hospital management.

2. A system of accounting can be, and has been, developed which meets the requirements of hospitals.

3. Mandating a uniform chart of accounts for all hospitals will make it necessary for individual hospitals to maintain duplicate accounting systems.

4. Uniform reporting by hospitals can be achieved with adequate definition of reporting requirements but does not require a mandated uniform chart of accounts.

5. Existence of significant differences among hospitals severely limits the validity of comparisons of reported results.

6. Substantial additional costs would be incurred to install uniform accounting in hospitals with no demonstrated evidence of the cost effectiveness of such effort.

HFMA and its Principles and Practices Board

The Hospital Financial Management Association was formed in 1946 as a not-for-profit association. Its over 14,000 members are directly or indirectly associated with financial management in hospitals and other health care institutions in the United States, Canada and several foreign countries. Membership in the 74 local chapters brings both national and local educational and other professional benefits.

The increasing complexities of accounting, the growing regulation of the health industry and the proliferation of agencies and organizations which influence health care accounting principles and practices have caused concern for the HFMA membership. In October 1974, the HFMA Board of Directors formed a task force to examine accounting and HFMA's role in formulating positions on issues related to these principles and practices. Following the recommendations of the task force, HFMA created a Principles and Practices Board (P&P Board) consisting of 12 outstandingly qualified individuals.

After reviewing a long list of issues, HFMA assigned the issue of uniform accounting and reporting to the P&P Board. A task force was formed to begin deliberation on December 5, 1975.

There are three distinct stages in the development of a position statement by HFMA's P&P Board. First, a ***background paper*** *is prepared to document views on the issue from a variety of sources. The background paper is intended to produce thorough understanding of the issue and avoid additional study and consideration if the weight of the evidence discloses that the issue has been resolved.*

Next, a ***discussion memo*** *is prepared, detailing the questions related to the issue and the alternatives to these questions. Based on the discussion memo, all HFMA members are asked to review the questions and alternatives carefully and express their views.*

After the comments in response to the discussion memo are reviewed, the task force prepares an ***exposure draft*** *of a position statement. The exposure draft is distributed to HFMA members, other individuals and organizations such as the American Hospital Association and the American Institute of Certified Public Accountants. All readers of the exposure draft are asked to submit written comments for the Board to consider before it adopts a final position.*

A Principles and Practices Board statement is intended to be responsive to a general membership concern rather than reactive to any specific events. It represents the views of the members of the P&P Board, the special task force and the many, many members and others who participate in its preparation. Finally, distribution of the statement is approved by HFMA's Board of Directors.

P&P Board members

William Freitag, CPA, FHFMA
Brad Hinker, CPA
Robert Jordan, CPA
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HOSPITAL INDUSTRY ANALYSIS REPORT

1981-1985

WILLIAM O. CLEVERLEY, Ph.D., CPA
THE OHIO STATE UNIVERSITY

1986-7th EDITION

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RONALD R. KOVENER,
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VICE PRESIDENT

March 11, 1987

The Healthcare Financial Management Association (HFMA) has been concerned that many important decisions about Medicare's price setting system are being made on the basis of dated information. Hospitals are in an environment of rapid change, and data from a few years ago is not valid for today's decisions. We are concerned that Congressional decisions about rates of payment for Medicare services are based only on data about hospitals' financial operations in the first or second year of prospective price setting. Accordingly, the effect of recent legislation on years three, four, or future years are not being adequately considered.

We asked chief financial officer members of HFMA to provide current financial information about their organizations. That information has been received and tabulated. The attached report summarizes the information collected, offers related information about the current financial status of hospital operations, quotes selected respondents about the data they reported, and describes the survey.

The Healthcare Financial Management Association is the nation's leading personal membership organization of more than 25,000 professionals concerned with financial management of institutional healthcare providers who are employed by hospitals, long-term care facilities, public accounting and consulting firms, insurance companies, government agencies, and other organizations.

We are pleased to provide the enclosed information and look forward to working with you to help you understand the financial operations of institutional healthcare providers.

Sincerely,

RR Kovener

R. R. Kovener
Vice President

RRK/mp

enclosures

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
Current Financial Information
Survey Report

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ABOUT THE SURVEY

HFMA members who are chief financial officers of U.S. hospitals responded to the survey of current financial information. About 950 responses have been received. This report includes data from 614 surveys that were received by the processing deadline and had fully useable data.

The survey asked for hospital data from four fiscal years -- 2 years ago, last year, the current year and next year. Hospital fiscal years end on various dates. For a hospital with a year end of December 31, the years reported would have ended December 31, 1985, 1986, 1987, and 1988.

Responses are more heavily representative of hospitals east of the Mississippi (64.3 percent of responses vs. 53.1 percent of hospitals), of hospitals over 100 beds (83.0 percent of responses vs. 54.5 percent of hospitals), and of metropolitan hospitals (66.1 percent of responses vs. 53.3 percent of hospitals).

The information about the length of time taken to process bills and to receive payment is from a separate survey sent to HFMA members that are patient accounting managers. In response to this survey, HFMA received information from approximately 800 provider organizations.

We gave respondents the opportunity to explain the data they reported. Some gave permission to quote their comments. These quotes are included with the related data. HFMA comments about certain of the reported information is also included.

Margin from Providing Patient Care Services

Data

	Profit %	Annual Change	3-year Change
2 years ago	3.6		
last year	2.1	down 42%	
current year	1.2	down 43%	
next year	.9	down 25%	down 75%

HFMA Comment

Profit margins from patient care reflect profitability from all such services, not just Medicare. This decline since PPS began reflects increased discounting from established charges; increasing costs of services; shifts to outpatient; and, of course, reductions in Medicare payment and the move to national rates.

What HFMA Members Said

"Due to the funding levels of the inpatient Medicare reimbursement remaining constant or slightly decreasing, most of our overall net revenue growth has been achieved in the outpatient sector since 1984. Should Medicare implement limitations on the outpatient surgeries and additional ancillaries, it will become increasingly difficult to cover the increase in costs we are presently experiencing."
William E. Baecker, Clinton Memorial Hospital, Wilmington, Ohio

"This Hospital's major problem is a declining activity level, 13.3% decline in admissions for fiscal year 1986, while the gap between charges and Medicare payments increased 15.5% for the same year."
James F. Neuses, Burnham City Hospital, Champaign, Illinois

"Our outpatient volume increase is the only thing that has held our bottom line."
Kenneth L. Simpson, Howard County Hospital, Nashville, Arkansas

March 11, 1987

Margin from Serving Medicare Patients

Data

	Profit %	Annual Change	3-year Change
2 years ago	5.3		
last year	4.5	down 15%	
current year	1.5	down 66%	
next year	loss 1.1	down 173%	down 121%

HFMA Comment

Historic reports of limited profitability from all healthcare activities make recently published high estimates of Medicare profits questionable. In the survey, we asked hospitals to report the cost of serving Medicare patients. This was not necessarily from the Medicare cost report. Since Medicare cost reporting defines what costs Medicare wishes to pay, rather than the true cost of treating patients, hospital-specific data represents the best indicator of costs. (For comments about the HHS Inspector General's profit methodology, see page 11.)

What HFMA Members Said

"In the first year of PPS ending 4/30/85, Community Hospital had one cost outlier resulting in $13,000 write off in charges. In the second year ending 4/30/86, there were 16 cost outliers resulting in write off of charges in the amount of $286,000. During this current fiscal year during the first 8 months, we have had 12 cost outliers resulting in $282,000 write off of charges. For the small rural hospital, this can be devastating."
Barbara Markham, Community Hospital, Grand Junction, Colorado

"We have been experiencing larger and larger losses on Medicare patients which has been made up by profits from other payors."
Ron Riechman, Firelands Community Hospital, Sandusky, Ohio

"As a very low cost Hospital, the Medicare rate increased significantly between 1985 and 1986 as the Hospital specific rate progressed toward the federal rate. However, rural hospitals in Pennsylvania are experiencing significant declines in reimbursement as our federal rate progresses from regional to national. Rural Pennsylvania hospitals also took a sharp drop in the wage index on 5/1/86. This is offset to some degree at our hospital by a steadily increasing Medicare utilization and significant increases in the CMI."
William F. Stoltzfus, Evangelical Community Hospital,
Lewisburg, PA.

(Hospital reported a loss on serving Medicare patients starting in the current year--FY87.) "Our facility is still seeing a downward trend in number of discharges (Medicare and total)

Margin from Serving Medicare Patients continued...

through at least FY87 with some bottoming out occurring in FY88. Coupled with an upward movement in case-mix index a rather flat Medicare revenue and expense projection is seen through FY88. Any upward trend in Medicare reimbursement is seen as a very slow, sluggish process with relatively flat long-term results. Additional unfavorable pieces of legislation, such as the proposed outpatient surgery limits, capital incorporated in DRG payments, Gramm-Rudman reductions, et. al., could move the slow upward trends the other way."

Larry Kidd, St. Alphonsus Regional Medical Center, Boise, Idaho

Medicare's Share of Total Cost

Data

	Cost	Annual Change	3-year Change
2 years ago	35.53		
last year	35.30	down .6%	
current year	34.91	down 1.1%	
next year	34.85	down .2%	down 1.9%

HFMA Comment

Medicare's share of cost has steadily declined, reflecting decreases in providing Medicare inpatient services. At the same time, the intensity of services provided to Medicare patients has increased. Providers have experienced more rapid decreases in Medicare payments, resulting in the losses reflected in the previous item. Providers rely more heavily on their non-Medicare business to maintain viability.

What HFMA Members Said

"The less sick are treated as outpatients -- sicker patients as inpatients."
James K. Long, CPA, Community Memorial Hosp., Hettinger, North Dakota

"Patient acuity is greater as less ill patients are treated as outpatients."
James P. Jackel, Mercy-Memorial Hospital Corp., Monroe, Michigan

March 11, 1987

Medicare Cost Per Case

Data

	Cost	Annual Change	3-year Change
2 years ago	3,387		
last year	3,854	up 13.8%	
current yea	4,146	up 7.6%	
next year	4,259	up 2.7%	25.7%

HFMA Comment

This data reflects the change in Medicare cost per case. These changes reflect increases in cost and complexity or severity, net of any cost reductions through improved efficiency. While Medicare's cost per case has increased by nearly 26 percent over the 3-year period, Medicare payments have remained relatively stable.

What HFMA Members Said

"As patients are more acutely ill now even to be admitted than they were several years ago, the number of, and services required by these patients has increased dramatically. Medicare outlier reimbursement doesn't even come close to paying an adequate amount for these patients."
Steve Slabik, Dakota Hospital, Fargo, North Dakota

"The severity of illness seems to have increased greatly in recent years, and very little of that increase is reflected in the case mix index."
Guy Benge, Kettering Medical Center, Kettering, Ohio

Percent of Uncompensated Care

Data

	Percent	Annual Change	3-year Change
2 years ago	5.4		
last year	5.5	up 1.9%	
current year	5.5	--	
next year	5.5	--	up 1.9%

HFMA Comment

Uncompensated care as a percent of revenue has remained relatively stable over the four years. However, as revenue has grown the absolute dollars of uncompensated care has grown. This has occurred in the wake of reduced Medicare revenues, forcing providers to rely more heavily on non-Medicare payers to support uncompensated services.

An HFMA publication, "Definition of and Payment for Uncompensated Services and Special Problems of a Disproportionate Share," is available on request.

What HFMA Members Said

"Increased outpatient activity is producing increased collection problems."
Norman T. Gaffrey, Divine Savior Hospital, Portage, Wisconsin

"Since the introduction of the Prospective Payment System, our Hospital has experienced a tremendous increase in...bad debts primarily due to the inadequate Medicare payments for terminally ill patients who require much longer and more intense treatment. We are a small, rural, sole community Hospital which is finding it very difficult to survive and continue as a viable healthcare facility rendering quality care to our community."
Janice W. Cross, Tippah Co. Hospital, Ripley, Mississippi

"As an 'Inner-City' Hospital, indigent care is by far the most serious financial problem facing us today."
Cary McClure, Bethany Medical Center, Kansas City, Kansas

Billing Lag -- Medicare

Data

Days from discharge to claims submission -- Medicare:

Average	18 days
Shortest lag	3 days
Longest lag	107 days

HFMA Comment

Time required for bill submission reflects the increased coding and information required from providers by payers, particularly Medicare. To the extent that data requirements and appropriateness review activity increase, additional time may be required. Since Medicare is only required to pay "clean claims" within a specified period from bill submission, increases in coding and processing requirements may also adversely impact the proportion of clean claims, further delaying payment.

Payment Delay -- Medicare

Data

Days from claims submission until payment -- Medicare

Average	26 days
Shortest delay	2 days
Longest delay	145 days

HFMA Comment

Payment delays can be anticipated to increase when Medicare eliminates the periodic interim payment (PIP) program on 7/1/87. Currently, there is a 21-day delay included in the PIP formula. The combination of time from date of discharge until claim submission (18 days) and from claim submission until payment (26 days) totals 44 days. This is more than double the present payment lag included in PIP and represents an increase in working capital requirements for providers. This increased demand for working capital occurs during a period of declining profitability.

March 11, 1987

Percent of Capital Cost of Total Cost

Data

	Percent	Annual Change	3-year Change
2 years ago	8.3		
last year	8.5	up 2.4%	
current year	8.5	--	
next year	8.8	up 3.5%	up 6.0%

HFMA Comment

Capital cost as a percent of total cost increased slightly over the years surveyed. The pattern indicates a flattening during the middle years fostered by uncertainty in the payment system. It is anticipated that providers who have delayed investment will no longer be able to do so. Therefore, increases in the proportion of costs devoted to capital are anticipated. If capital is paid as a proportion of the PPS rate, an increase in the ratio is especially disadvantageous.

What HFMA Members Said

"From 1984 to 1987, plant-related capital expense and equipment-related capital expense have continued to increase due to the ongoing renovation project of Mount Clemens General Hospital. In 1986 plant-related capital expense decreased slightly due to the drop in interest rates on the hospital's construction loans. With the completion of the project at the end of 1986, full depreciation for the newly renovated areas and new equipment for these areas will begin in 1987 causing a more dramatic increase in capital expense from 1986 to 1987."
Susan Colonius, Mount Clemens General Hospital, Mt. Clemens, Missouri

"In 1984, Methodist Hospital completed a construction project consisting of a new building addition, total cost was approximately $3,700,000. Therefore depreciation and interest expense have increased significantly since 1984."
Lisa Vasa, Methodist Hospital, Mimitchell, South Dakota

Percent of Capital Cost that is Equipment

Data

	Percent	Annual Change	3-year Change
2 years ago	42.5%		
last year	43.1%	up 1.4%	
this year	45.0%	up 4.4%	
next year	43.7%	down 2.9%	up 2.8%

HFMA Comment

Since equipment and plant capital may be incorporated into PPS separately, this ratio and its stability are important.

What HFMA Members Said

"High technology diagnostic equipment demands major capital resources for the provision of high quality medical care."
Bradley N. King, CPA, Sacred Heart General Hospital, Eugene, Oregon

General Comments

Many members were anxious to express their views. However, some comments did not fit into the above categories. Below are several quotes which present a general sense of frustration about Medicare payments.

"The trend in total net acute inpatient revenue is steadily downward as every purchaser of care determines in every way conceivable to pay us less while steadily demanding more service, more paperwork, more evaluation, more copies, more meetings, more documentation, more, more, more. They tell us how to manage, how to give what care, and how much they'll pay. The rest is up to us. If we make too much (their opinion) on a DRG they cut the weight, they rebase the standards, they increase the outlier (threshold) and reduce the blended rates, they reduce capital, they reduce medical education, they cut the market basket by 2/3. There's blood (ours) all over the place."
Dave Hamilton, Ingham Medical Center, Langsing, Michigan

"Many rural facilities are very dependent on the appropriateness of Medicare funding and will cease to exist in a very short period of time."
Richard P. Derbey, FHFMA, CMPA, St. Joseph's Hosp., Dickinson, North Dakota

"Our plant is debt free and we do have a significant funded reserve, which is one of the reasons that our non-operating revenue is of the amount shown...Our operating statistics are not reflective of the situations being encountered in other hospitals in our area. I do however feel that figures such as ours are being taken out of context by the Health Care Financing Administration and generally are used to state that the entire industry is in a very enviable position."
Frank A. Quiriconi, FHFMA, St. Dominic's Hospital, Jackson, Mississippi

"Expenses will be held in check for FY 87 by decreased staffing, but staffing is now to the bare minimum and I see no further reductions in staffing without a reduction in services."
Donald E. Buchanan, CPA, Aurora Community Hospital, Aurora, Missouri

"As the PPS rate moves more to a national rate, our actual payment per DRG decreases from the previous year, even after the update factor has been applied."
Steve Slabik, Dakota Hospital, Fargo, North Dakota

"For the last 2 years we have economized our costs and have shown a profit. With costs controlled as much as possible, and without major changes in Medicare reimbursement, we project major losses in fiscal 1989."
Ronald James, Floyd County Memorial Hospital, Charles City, Iowa

March 11, 1987

Comments on the Inspector General's Profitability Data

The profit (or loss) on serving Medicare patients presented on page 2 is in sharp contrast to the HHS Inspector General's (IG) reports of profits as high as 14 percent or 15 percent on these activities. Several factors contribute to this difference, including:

1. The IG's report of high profit on Medicare is inconsistent with well-documented profitability from operations for the industry. HFMA's Financial Analysis Service, which has compiled audited financial report information from approximately 1,400 hospitals, shows overall profit in 1984 and 1985 of 3.9 percent. These years roughly coincide with the first and second years of PPS. Medicare comprises 34 percent of total net revenue, according to this HFMA survey. A loss on all of the 66 percent of non-Medicare activities is required to produce a Medicare profit of 15 percent. This result is clearly illogical.

2. The profit percent calculated by the IG was inflated by basing the percent on payments rather than charges as is customary and excluding Medicare payments for capital-related cost, direct medical education, and bad debts. The following table illustrates how these factors inflate the percentage. If we assume total payment 17 percent* less than charges and the excluded cost comprise 20 percent of Medicare payments:

	Charges	Payment Less than Charges	Medicare Payment	Excluded Items	IG Profit Percent
Revenue	1,205	205	1,000	200	800
Cost**			880	200	680
Profit	120		120		120
Profit%	10%		12%		15%

*The median ratio of charges to payments according to HFMA's Financial Analysis Service

**This amount does not accurately describe Medicare costs but is the amount necessary to yield the profit percentages included in the IG's calculations

3. The costs reported on the Medicare cost report do not accurately describe and in many cases understate Medicare costs. Examples of Medicare inaccuracies in calculating the cost of serving Medicare patients include:
   - failure to correct PPS rates for court decisions,
   - a formulae for allocating malpractice, bad debt and home office cost that results in Medicare paying less than its proportionate share of these costs,

- using data about non-Medicare maternity services to dilute the calculation of the average daily cost of Medicare services,
- failure to pay any share of the cost of serving indigent patients or costs of ownership; and,
- failure to recognize the higher cost of serving elderly patients.

HFMA asked hospitals in this survey to report the cost of serving Medicare patients based on their cost accounting systems. Over 200 hospitals were able to provide this information.

4. The IG report fails to project the effect of existing rules and payment rates on future profitability. It is also appropriate to consider the artificial reductions in rates that have offset real increases in case complexity. HFMA's survey clearly shows the significant decline in profit resulting from these rules and payment rates.

Chairman **Stark**. Thanks to all of you.

Let me get to some clarification here. Everybody talks about cost reports, which I gather is what HCFA has been requiring all these years.

Is that correct? Do not those cost reports include some revenue as well?

When you talk about cost reports, do you mean reports that have no revenue side to them at all?

Mr. **Clarke**. There is revenue.

Chairman **Stark**. All right. So we can talk about reports. We are not going to get bogged down in whether there should be revenue information, whether it is from charitable contributions or payments by patients or insurance companies. Would there be agreement in the panel that for any kind of reporting we ought to have both sides of the equation so we can understand what there are? Is everybody nodding yes?

Mr. **Ferman**. Yes.

Ms. **Scanlan**. Yes.

Mr. **Clarke**. Yes.

Chairman **Stark**. Second, we are also talking about Medicare. Would you all agree that it really would be simpler for everybody if we lump all services into the report: Medicaid, Medicare, private insurance, the whole thing for all the revenue and all the expense and all the patients that a hospital has? Is that fair?

Mr. **Ferman**. Yes.

Ms. **Scanlan**. Yes.

Mr. **Kovener**. Depending upon your use of the information. If you are interested in overall costs, absolutely. If you want to isolate costs of serving Medicare patients, that would not be adequate information for that purpose.

Chairman **Stark**. It would not be adequate. I am just suggesting that I have seen reports in statements from hospitals that tend to show me or purport to show me that they are losing money on Medicare; whereas, the hospital in its entirety seems to be quite healthy.

But you never see that side of it. And I am just suggesting that if we have all the information, we can make decisions about hospitals that serve a larger or smaller percentage of Medicare or Medicaid beneficiaries. Does that make sense?

Mr. **Kovener**. Yes. I think that it is very important that you have both the broad perspective as well as the perspective of an individual part.

Chairman **Stark**. Okay.

Mr. **Kovener**. Just as in your bank you would want to know commercial loans as different from real estate and so forth.

Chairman **Stark**. Okay. Now, also, when defining accounting, we used the word "accounting" and "reporting." Does the panel all agree that we could have a uniform reporting system but that would not require a uniform chart of accounts for all hospitals?

Ms. **Scanlan**. Yes.

Mr. **Ferman**. Yes. That is true.

Mr. **Clarke**. Yes.

Chairman STARK. So then, in effect, you would not necessarily require a hospital to keep two sets of books, but to use their present set of books to extract a report.

Mr. FERMAN. Yes.

Ms. SCANLAN. Yes.

Mr. CLARKE. Yes.

Chairman STARK. And nobody has any objection to hospitals reporting revenue from private payers. Is that also correct, assuming that there is suitable confidentiality?

Mr. FERMAN. Yes.

Ms. SCANLAN. Yes.

Mr. CLARKE. Yes.

Chairman STARK. Okay. There are some questions here that I would like to submit to you all in writing which get to the timeliness and the details of some of the reports that some of you use. I will skip those for now.

Now to New York and California. Would it be a horrendous problem for either California or New York to take the other's reporting form and use it?

Mr. FERMAN. Yes.

Ms. SCANLAN. Yes.

Chairman STARK. Okay. Now, we are getting to the tougher part. For the two of you, what are the problems? You have the two largest number of hospitals. You have 600. How many does New York have?

Ms. SCANLAN. 280.

Chairman STARK. Only 280 hospitals. How come you have so many less than we do?

Ms. SCANLAN. We had a stronger certificate of need program.

Chairman STARK. That is good to know. What is your occupancy?

Ms. SCANLAN. Eighty-two percent.

Chairman STARK. What is ours?

Mr. FERMAN. Sixty-six.

Chairman STARK. I like that. Okay.

John, and then Carolyn second, what would you have to do to use New York's plan?

Mr. FERMAN. We have a uniform accounting system in place now. We would have to change the system to account for the reporting requirements of New York. And I do not know what New York's accounting system is.

Chairman STARK. How much? That is what we are getting at.

Mr. FERMAN. I do not know.

Chairman STARK. How difficult would it be to take your accounting system and extract from that a report that would meet New York's report?

Mr. FERMAN. I do not know the answer to that.

Chairman STARK. Do you know?

Ms. SCANLAN. I do not know. My sense is that since our hospitals all use different chart of accounts, since we do not have a uniform accounting system, that it should be something that is, while not easy, certainly do-able because it occurs currently in the state for the 280 hospitals that we do have.

Chairman STARK. Now, you say you do not. Is it a system that has generally one or two kinds of accounting, or do you have hundreds of different charts of accounts?

Ms. SCANLAN. I do not think it is hundreds, but it is certainly more than one or two. Because of the diversity of the kinds of hospitals we have, from major teaching hospitals in New York City to small rural hospitals of 18 beds, they need to have different kinds of accounting systems.

Chairman STARK. Could we suspend for just a moment?

[Brief recess.]

Chairman STARK. Excuse me. We will continue. I apologize.

For the audience and for the other witnesses, I normally would plan to work through lunch, but our fraud and abuse bill is first up on the floor, and I am not sure how many 1 minutes there will be today. I doubt very many.

So, it will be my intention to recess until 1 o'clock.

Coming back to New York and California, and I am sure that you understand that I am trying to elicit the information to see what our problems would be in going to a reporting system.

As I understand, Ms. Scanlan, you are saying that you feel New York could fill out the California form.

Ms. SCANLAN. No. I think the other way around, that California could fill out the New York form.

Chairman STARK. Because you used to. Okay.

John, would you try that as an exercise for the committee and let us know. I am not beginning to suggest a prejudice here as to which form we would use, but it would seem to me that if two very large States with this difference, that one has a uniform chart of accounts and the other one doesn't, we might at least do away with some extended debate on how much of a problem that is.

Mr. FERMAN. Sure.

Chairman STARK. How would each of you characterize the major differences in what is in your reports?

Ms. SCANLAN. I have not had an opportunity to study the California reports so I could not give you a good answer.

We, when you took the break, intended to exchange forms and do that.

Mr. FERMAN. We can do that.

Ms. SCANLAN. We will be prepared to give you an answer in writing.

Mr. FERMAN. In writing.

Chairman STARK. Okay.

[Questions submitted to the panel, and responses received follow:]

QUESTIONS FOR PANEL ON UNIFORM REPORTING

1. Are there data elements in the present Medicare cost report which are obsolete or outdated?

Would updating the Medicare cost report through development of a new uniform report therefore prove helpful in removing obsolete or outdated data elements?

2. There appear to be several problems leading to a lack of timeliness in making Medicare data available for analysis and policy development.

First, how can we deal with the problem of different hospital accounting years, a problem which contributes approximately 20 months to the delay? Do California's quarterly reports make sense in this regard?

Second, can we reduce the present 120-day time period after the close of an accounting year that hospitals have to report?

Third, can we reduce the approximately 180-day period which the fiscal intermediaries hold the data, perhaps through increases in their budgets?

Fourth, HCFA appears to spend an inordinate amount of time putting the data in reportable form. Can we reduce that time period?

3. California's quarterly reports are based upon unaudited data. Are there discrepancies between the data reported on the quarterly report and that reported on the annual report?

4. Section 1121 of the Social Security Act already requires the development of a new uniform reporting system for hospitals and other healthcare facilities. Given that, what is the best way to proceed to develop a new hospital reporting system?

Can we simply promulgate the Annual Hospital Report developed by HCFA and released August 15, 1980? Is it still relevant?

Can either New York or California's reporting systems be adopted for the nation as a whole?

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

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July 10, 1987

The Honorable Fortney H. Stark, Chairman
Health Subcommittee
Committee on Ways and Means
1114 Longworth House Office Building
Washington, D.C. 20515

Dear Pete:

Attached is our completed comparative analysis of the uniform reporting requirements of New York and California. Also attached are our answers to the Subcommittee's questions on uniform reporting. We gave David Abernethy a preliminary draft a week ago.

We strongly support and encourage a complete revision of Medicare's cost report; it is mostly obsolete and still calculates reimbursement under cost reporting principles. The current report requires detailed data which provides no meaningful information relative to the impact of Medicare's prospective payment system or the institution's financial viability.

Any revision should be "steamlined" and provide comparison of hospitals' actual costs of providing services to Medicare payments received. The arbitrary "reasonable cost" standard is no longer appropriate.

An honest evaluation requires the Subcommittee to see the full financial picture.

We remain available to help in any way.

Respectfully,

John H. Ferman
Executive Vice President

JHF:dmm

attachment

cc: Brian Biles
David Abernethy
C. Duane Dauner
Steve Jones
Carolyn F. Scanlon
Jack Owen

Representing California Hospitals and their Health Systems

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

CAHHS

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July 6, 1987

Analysis of Uniform Reporting and

Response to Subcommittee's Questions

The following is an analysis of uniform reporting in New York compared with uniform reporting in California, and our responses to the four questions raised by the Panel on Uniform Reporting. This report was prepared by Stephen Clark, Health Systems Finance Specialist, California Association of Hospitals and Health Systems.

The analysis was performed by following the New York Insitutional Cost Report, ICR (similar to the Medicare Cost Report itself) and Supplement to the ICR, and comparing those with the Annual California Office of Statewide Health Planning and Development, OSHPD, (formally CHFC) disclosure report. In addition, references were made to the Medicare Cost Report, filed by all hospitals, where appropriate. Please note, as we discussed, specific line or column differences will not be addressed at this time, and only major differences will be highlighted.

Trial Balance of Expenses:	The New York ICR provides a more detailed breakdown of expenses then the Medicare cost report, i.e., Fiscal Services are detailed by department, Routine Services are segregated by room type, and physical medicine programs are specified. The detailed expenses themselves are separated between Salaries and Other. The California OSHPD report provides an even more detailed breakdown of departmental expenses. In addition to those noted above, the specific departments related to Research, Education, General and Administrative Services are segregated. Also, the expenses are classified between Salaries, Benefits, Professional Fees, Purchased Services, Supplies, Depreciation, Rent and Other.
Schedule of Outside Contracts:	The New York ICR provides a table for listing all outside contracts and associated departments. The California OSHPD provides the Purchased Services by Department in a similar manner.

Representing California Hospitals and their Health Systems

Schedule of Non-Paid Workers:

The New York ICR provides a table for the names and imputed salaries of all non-paid hospital workers.

The California OSHPD does not provide this information.

Reclassification and Adjustments:

The New York ICR provides the Wks A-6 Reclassifications and Wks A-8 Adjustments in a similar manner as the Medicare Cost Report. However, these only relate to reimbursement issues.

The California OSHPD is not a reimbursement oriented report and does not provide for these classifications or adjustments.

Cost Allocation: Process:

The New York ICR provides for an allocation of overhead department expenses to patient care departments; as does the Medicare Cost Report and the California OSHPD report. However, some notable differences with the Medicare Cost Report include:

a) The additional support departments, discussed in the Trial Balance of Expenses Section, result in more departments to be allocated and additional allocation statistics then the Medicare Cost Report.

b) The administrative and general cost center is allocated, based on accumulated cost, near the end of the process, after most support costs have already been allocated to administration. The Medicare Cost Report allocates the administrative department third, at the beginning of the process.

c) The allocation statistics are comparable between the ICR and Medicare Cost Report.

The California OSHPD cost allocation is completely different. Many different departments are grouped together and allocated based on a common statistic . The statistics used for allocation are very different. For example, Medical Records costs are allocated based on "percentage of time" for the ICR and "gross revenue" for the OSHPD. Also, the order of the allocation process is different between the two reports, as in the administration and general example given earlier.

Cost Allocation - Ancillary: The New York ICR allocates the ancillary departmental expenses utilized by the ambulatory departments to the appropriate ambulatory departments.

The California OSHPD or Medicare Cost Report does not perform this additional "step-down" of costs.

Revenues: The New York ICR provides for departmental revenues by payor for the ancillary departments. The New York Supplemental adds the departmental revenues, not by payor, for the routine and ambulatory departments. The supplemental report also provides for inpatient ancillary departmental revenues by numerous payors, i.e., Medicare, Medicaid, Blue Cross, Workers Compensation, No Fault Auto, other.

The California OSHPD provides for routine and ancillary department revenue by inpatient and outpatient; and by Medicare, Medi-Cal and Other.

Revenue Deductions: Supplement to New York ICR provides revenue deductions by departments by payor.

California OSHPD provides revenues deductions by payor. Not departmentalized, intentionally eliminated due to inaccuracies in reporting.

Statistics: The New York ICR supplemental provides similar statistics as the California OSHPD report for the ancillary departments. They are provided by inpatient and outpatient, but not by payor. The patient census statistics, like revenues, are provided for Medicare, Medicaid, Blue Cross, Workers Compensation, No Fault Auto and Other. No statistics, other than allocation statistics, are provided for the support departments.

The California OSHPD provides ancillary statistics by inpatient and outpatient and by payor. Patient census statistics are provided by Medicare, Medi-Cal and Other. Statistics for overhead departments are required.

Payroll Information: The New York ICR Supplemental provides FTE's and average hours worked by Department.

The California OSHPD provides a very detailed payroll report. Productive Hours and Average Hourly Rates are required by departments and by employee classification, i.e., payroll information related to laboratoy is detailed by hours for management, technicians, nursing, clerical, other. Also, non-productive hours by department are required.

Other Information:

New York ICR provides the following additional items not provided by California OHSPD:

1) Detailed analysis of newborns,
2) Detailed information on Educational Programs,
3) Detailed information on Ambulatory Care Programs,
4) More detailed accounting of expenses in employee health and welfare and plant operations.

California OSHPD provides the following additional items not provided by New York ICR:

1) A detailed Services Inventory,
2) A more detailed physician compensation analysis.

Financial Statements:

Both reports require the basic financial statements, i.e., Balance Sheet, Income Statement, Statement of Changes in Equity, and Statement of Changes in Financial Position. ICR NY requires a reconciliation to the audited financial statements, OSHPD CA does not.

RESPONSE TO PANEL QUESTIONS

1. Are there data elements in the present Medicare cost report which are obsolete or outdated?

   *Would updating the Medicare cost report through development of a new uniform report therefore prove helpful in removing obsolete or outdated data elements?

Answer: Most of the Medicare cost report is obsolete in terms of establishing reimbursement levels and measuring financial viability. Once both inpatient and outpatient services are all paid on a fixed schedule only the settlement pages will be necessary (Wks E series). The rest of the report to establish reimbursable costs (Wks A-F, excluding Wks E) will only be meaningful to measure the financial viability of the hospital in detail. The Worksheet G series, financial statements, however, show the financial picture without providing the detail.

The establishment of a new uniform report to replace the cost report could help eliminate the collection of useless data if the report was developed with a specific purpose in mind. In other words, know what it is you want to accomplish with the report first; then establish the data collection elements based on that premise; not the other way around. As long as the current cost report is in existence, no matter what its purpose is, it will not likely eliminate the collection of obsolete data elements. For example, under PPS the auditing of many obsolete items is irrelevant, yet Medicare auditors spend days auditing useless data elements and requesting documentation from the hospital.

2. There appear to be several problems leading to a lack of timeliness in making Medicare data available for analysis and policy development.

   * First, how can we deal with the problem of different hospital accounting years, a problem which contributes approximately 20 months to the delay? Do California's quarterly reports make sense in this regard?

   * Second, can we reduce the present 120-day time period after the close of an accounting year that hospitals have to report?

   * Third, can we reduce the approximately 180-day period which the fiscal intermediaries hold the data, perhaps through increases in their budgets?

   * Fourth, HCFA appears to spend an inordinate amount of time putting the data in reportable form. Can we reduce that time period?

Answer: First, the only way to eliminate the problem of different hospital accounting years is to require uniform accounting years. It would be very difficult to shorten this 20 month delay since hospitals will require 4 months to submit their reports. This means that we already have a 12 month gap due to fiscal years alone plus 4 months to submit their reports. So there is at least a 16 month delay if everything goes right and filed, not audited, reports are released. The Quarterly Report is an alternative to uniform fiscal years; but unless it is simple it will increase both the hospital and HCFAs workload by four times.

Second, the 120 days following fiscal year end due date cannot be shortened. Although cost reports are due in 90 days, most hospitals take at least another 30 days to submit the information. This is due to the time it takes for a hospital to close its books, to receive its year-end audit, then to prepare its report. Most year-end CPA audits are not completed until 3 months after fiscal year.

Third, the fiscal intermediary should not hold the data for 180 days before release. For purposes of aggregate date studies the actual filed cost reports or disclosure reports will not be significantly altered.

Fourth, the reports should be developed and submitted in a format that eliminates a re-formatting of the data. This appears to be an unnecessary step.

3. California's quarterly reports are based upon unaudited data. Are there discrepancies between the data reported on the quarterly report and that reported on the annual report?

Answer: There are discrepancies between the annual reports and the quarterly reports; even between quarters. However, these are resolved routinely through calls to the hospital seeking explanations. Sometimes there is an error; sometimes the discrepancy is justified and is explained by a change in accounting procedure or by some extraordinary occurance.

4. Section 1121 of the Social Security Act already requires the development of a new uniform reporting system for hospitals and other healthcare facilities. Given that, what is the best way to proceed to develop a new hospital reporting system?

   - Can we simply promulgate the Annual Hospital Report developed by HCFA and released August 15, 1980? Is it still relevant?

   - Can either New York or California's reporting systems be adopted for the nation as a whole?

Answer: We do not know if the Annual Hospital Report is still a viable option. The data contained in the last version was very similar to that in California at that time. However, a considerable amount of "streamlining" will be required.

An analysis of both New York's and California's reporting systems has been outlined in this paper. As can be seen by the analysis, both systems still provide for an excess amount of data collection, as does the current cost reporting, in fact, New York's system closely corresponds to the Medicare cost report. Again, a "streamlined" version of the New York or California system could be considered, but as mentioned before, the purpose of the data collection needs to be established before deciding which data is to be collected.

Hospital Association
of New York State

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June 19, 1987

Honorable Fortney H. Stark
United States House of Representatives
1125 Longworth House Office Building
Washington, D.C. 20515-0509

Dear Mr. Stark:

I would like to thank you for the opportunity to appear before the Health Subcommittee on June 1, 1987.

As you requested, enclosed please find the answers to the questions you transmitted to me on June 8, 1987.

I have also enclosed our detailed analysis of the California Cost Report. As the review indicates, we do not believe that the California Cost Report can be used as a model because of its uniqueness and incompatibility with accounting systems in the rest of the country, including New York State. We continue to believe that the New York State cost reporting system (because it has been designed to be used by multiple accounting systems, to serve as a substitute for the Medicare report, and to collect cost data in regard to all payors) could be implemented nationally.

If any additional information is required, please do not hesitate to call.

Sincerely,

Carolyn F. Scanlan

Carolyn F. Scanlan
Executive Vice President

cc: John H. Ferman
    Richard L. Clarke

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Hospital Association
of New York State

ANALYSIS OF CALIFORNIA COST REPORT

We have reviewed the cost report completed by the California hospitals. The California Cost Report is the end product of a comprehensive, uniform hospital accounting system assembled in a single "Hospital Accounting and Reporting Manual." An entire year's worth of daily operations are reported in the HARM. The focus of our review was to determine whether the federal cost report - the HCFA 2552 - and New York State's Institutional Cost Report could both be derived from a completed HARM.

California hospitals must complete a HCFA 2552 in addition to submitting a HARM. This indicates to us that a HCFA 2552 could not be generated from a HARM, otherwise the California Hospital Association, the hospitals, and the regulators would have all worked together towards that goal in order to avoid the burden and expense of additional cost reporting requirements.

Overview of the HCFA 2552/ICR and HARM Systems

1. HCFA 2552/ICR

The purpose of both systems (HCFA 2552/ICR and HARM) is cost finding but their approach is different. The HCFA 2552/ICR reports total hospital expenses, based on responsibility accounting, in a specific sequence with specific statistical bases allocating the general service cost centers to the other cost centers. This data generates a "stepdown" that is then used to determine the cost of the Medicare program and non-Medicare programs. Other worksheets include patient utilization data, balance sheet reports, statement of changes in fund balance, revenue and expense statements, etc.

Most of the worksheets in the HCFA 2552 and ICR are used for finding the costs of the Medicare program. These worksheets are generally referred to as the "Settlement Pages" of the cost report. Both the HCFA 2552 and the ICR can accommodate any size or type of facility, e.g., hospitals with subproviders, swing bed units, skilled nursing facilities, home health agencies, renal dialysis centers, hospice and Comprehensive Outpatient Rehabilitation Facilities (CORFs). The Settlement Pages are where the bottom-line total costs of each Medicare program are calculated and where the net "Due To/Due From" figure between the hospital and Medicare is derived. There can be 150 pages of Settlement data from Worksheet C through Supplemental Worksheet E-2 on the cost report.

In New York, there are two supplements to the ICR that provide additional data in other areas (e.g., revenues by all third

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parties, and various utilization statistics). The "ICR" section of this memo expands upon the information in the Supplements.

2. HARM

The HARM also reports total hospital expenses. However, it is based on functional accounting rather than responsibility accounting. It also reports ancillary and other utilization statistics, patient revenue by third party for inpatient and outpatient. Other reports include: Detail of Direct Payroll Cost (in a 33-column spreadsheet); Service Inventory; Disclosure of Hospital Vendors and Contractors With Significant Interests; Patient Census Statistics; Balance Sheet; Statement of Changes; Supplemental Long-Term Debt Information; General Other Information and Certification Pages. There is no provision for the "Settlement Pages," which is central to a Medicare cost report.

Discrepancies Between the Two Systems

A HCFA 2552 could not be generated from a HARM report, for several reasons. The major discrepancy between the two reports relates to a difference in one of the fundamental principles of cost finding. In following the Medicare principles of cost finding and reimbursement for the HCFA 2552 and the ICR, costs are reported according to responsibility accounting. In the HARM, costs are reported based on functional accounting. This is a major philosophical difference, one that has far-reaching effects on the completion of the cost report. Even starting with identical data, the end results of the two reports would be substantially different.

In effect, these two types of reporting are in direct conflict with one another. Under responsibility reporting requirements (HCFA 2552 and ICR), costs are reported in that department which is organizationally responsible for incurring that cost. Under functional reporting requirements (such as HARM), all costs are reported in a specific predetermined cost center without regard to who is responsible for monitoring that cost.

For example, in many hospitals the operating room staff (OR) is responsible for cleaning the operating suites themselves. This OR housekeeping staff reports to the director of the OR. On an HCFA 2552 and on an ICR this would be reported as a direct cost of the operating room. On a HARM, this cost would have to be reclassified to Housekeeping, even though Housekeeping had no management control or responsibilities for the OR. Nevertheless, "functionally" speaking, cleaning the operating room is a housekeeping task.

Another example is nursing, again in the operating room. In many facilities the OR nurses report to the OR director; Nursing Administration is not responsible for the operating room. On an HCFA 2552 and on an ICR, this OR nursing expense is reported as a direct cost of the operating room. On a HARM, this nursing expense is functionally part of general nursing service and would be reclassified as such.

Reporting differences such as these examples occur throughout the entire hospital operation. Such reporting differences - functional versus responsibility - would impact the final results of cost finding during the stepdown process. It is clear that the ultimate allocation of costs among programs would not be the same on an HCFA 2552/ICR as on a HARM.

Often these functional reclassifications are made on the HARM cost report itself. However, California hospitals had the option of adjusting their accounting process so that costs would be immediately booked to the functional cost center instead of the responsibility cost center. In this case, the functional reclassifications would not appear on the HARM report. Without the detail of these functional reclassifications that were made prior to the HARM cost reporting process, it would not be possible to generate a HCFA 2552 from a HARM.

Even if it were possible to adjust for the non-compatibility of functional versus responsibility reporting, other major differences between the two reports still exist.

1. The cost centers follow a sequence different from the HCFA 2552 and the ICR. This becomes an issue in cost-finding. The order of allocation of the non-revenue cost centers impacts the total stepdown cost of the revenue-producing cost centers.

2. The statistical bases that allocate the non-revenue-producing cost centers in the HARM are often different from the statistical bases required in the Medicare cost report.

3. In the HARM, ancillary departments are allocated based on "SUMs" - Standard Units of Measure. In New York, ancillaries are allocated to inpatient and outpatient cost centers based on revenue statistics. The "SUM" statistics are not kept in the rest of the country for cost reporting purposes. Developing, implementing and maintaining the SUM statistics would add yet another reporting burden to an already over-regulated system. Many of the SUM statistics will require hospitals to go to the procedural level of detail (e.g., annual number of hand x-rays) for both the hospital and professional components to accurately compile required

statistical data. This is a monumental task for many of our New York hospitals, and I would venture to assume the same for other states.

4. In comparison to the HCFA 2552 and the ICR, the completed HARM reports very detailed sub-account information. It would take a significant amount of time to complete a HARM -- both throughout the year, in preparation for year-end reporting requirements, and in completion of the report itself. The HARM is much more time-consuming than the HCFA 2552 and the ICR and, in my judgment, does not represent the most effective means for capturing the costs. For one thing, much of the data could be aggregated. Also, other than cost finding, the purpose of such detailed reporting requirements is not made clear in the manual. Is the level of detail that results from the HARM that valuable to the financing and planning of the health care delivery system to justify the time and expense necessary to achieve this difference in cost finding? The overall objectives of cost finding can be met without these excessive reporting requirements.

5. Aside from other differences, the HARM expense worksheets do not allow for the proper, distinct reporting of hospital-based home health agencies, CORFs, Durable Medical Equipment, Home Program Dialysis, Kidney or Liver Acquisitions. Nor does it distinguish certain cost centers that Medicare does distinguish (Depreciation of Movable Equipment, Operating Room and Recovery Room). Also, it does not include discharges to a PPS-exempt unit in the total annual discharges as required by Medicare.

   The HARM expense worksheets do provide an extremely fine level of detail relating to the classification of expenses. For example, there are ten HARM classifications of salary expense compared to the one "Salary" category on HCFA 2552 and ICR. The HARM manual did not offer an explanation for the need of this detail.

6. The worksheets for reporting expense and non-revenue allocation statistics are the only worksheets that are even vaguely similar between the HCFA 2552/ICR and the HARM. The HARM excludes the rest of the Medicare cost report which I previously referred to as the Settlement Pages. The HARM includes tons of other financial and statistical information that are not necessary or central to Medicare principles of reimbursement.

   Another point that should be noted is that if HCFA and New York switched to a HARM type of system, comparisons between the future and the 1966-1986 time periods would not be valid.

Miscellaneous Other Data

1. ICR

New York hospitals complete an "Institutional Cost Report" (ICR). It is extremely similar to the HCFA 2552, and it follows all of the Medicare cost reporting principles. Most importantly, it is approved by HCFA as an acceptable substitute cost reporting form, i.e., New York hospitals do not have to complete a HCFA 2552. In addition to the data in the ICR proper, additional information appears in two supplements that provide cost-finding data for non-Medicare regulators. The New York State and Blue Cross Supplement to the ICR provides rate-setting data for Medicaid and Blue Cross, Worker's Compensation and others; the Department of Mental Hygiene Supplement to the ICR represents an important data base for all hospitals' mental health programs. This extensive data base should prove extremely useful to commercial insurance companies, individual health care providers, and all parties involved in the financing and planning of health care services. The ICR reporting forms themselves are all geared toward computer entry so that the entire New York State hospital financial data base is accessible to all parties. Generally, all of the reports are compatible with the Medicare principles of reimbursement.

2. New York State and HARM

The argument over functional reporting versus responsibility reporting is a long-standing one. In the late 1970's, New York State hospitals participated in a federally sponsored pilot program evaluating its own HARM report. It followed the same basic philosophy as California's HARM, i.e., uniform, functional accounting. The concept failed in New York for several reasons - most of which still seem applicable to the California HARM. The New York HARM (which later evolved into Statewide Hospital Uniform Reporting (SHUR) and the Annual Hospital Report (AHR) - before its demise) was evaluated by several of the Big Eight accounting firms as well as the Hospital Association of New York State. The accounting firms and HANYS were in agreement in their conclusion that the HARM would be extremely expensive and time-consuming to implement without presenting a clear rationale for all the data that the report required. It appeared that the report had been designed before the uses for all the data had been identified.

In summary, and in answer to the question, neither an HCFA 2552 nor an ICR could be generated from the data provided on a California HARM report because of the differences in reporting requirements (functional versus responsibility; different statistical allocation basis for many of the revenue and non-revenue cost centers; different sequencing order; discrepancy in definitions (e.g., discharges); lack of detail in certain areas such as home health agencies, CORF, et al.). These incompatibilities are apparent from our initial review. A more comprehensive analysis --with completed cost reporting and discussions with the California Hospital Association -- would surely uncover additional problems.

Hospital Association
of New York State

QUESTIONS AND ANSWERS
PANEL ON UNIFORM REPORTING
HEALTH SUBCOMMITTEE HEARING OF JUNE 1, 1987

Q. Would updating the Medicare cost report through development of a new uniform report therefore prove helpful in removing obsolete or outdated data elements?

A. The purpose, function and intended uses of data must first be determined in order to develop appropriate reporting forms and data elements to collect the necessary information. It must be determined whether the report is to be done on a functional or responsibility reporting basis. It is extremely difficult, time-consuming, expensive and increases the volume of data necessary to convert a responsibility reporting format to a functional reporting format and vice versa. The purposes of each are different. The reporting forms and data elements required must, therefore, be different. Given that the current Medicare reimbursement system is based on diagnostic related groups and 1982 cost reports, the cost reports are essentially irrelevant for providers being paid on the basis of DRGs. Obsolete and outdated data elements should be removed from the Medicare cost report in any event. To the extent that the report can be refined, it would aid in obtaining data more timely and accurately from providers being reimbursed on the cost basis instead of DRGs.

Q. How can we deal with the problem of different hospital accounting years, a problem which contributes approximately 20 months to the delay?

A. New York State has a mandated reporting year ending December 31. Hospitals wishing to report on a yearly period other than December 31 are required to obtain waivers. This did not present undue hardship at the time of the mandated change because less than 35 out of more than 300 hospitals in the state were using reporting periods other than December 31. With the multiplicity of fiscal year ends and state mandates, this does not appear to be an appropriate solution. However, the proposal which would require hospitals to report at the end of individual fiscal years and which would require HCFA to update and release a data file quarterly could create a data file which is no older than 20 months. This "rolling" reporting would obviate the need for uniform fiscal years, and is clearly better than the current data timeliness.

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Q. Do California's quarterly reports make sense in this regard?

A. Quarterly reports place four times the reporting burden on providers, certified public accounting firms and fiscal intermediaries. Quarterly reports will not provide data as accurate as 12 month reports and increase the cost to all without any increased benefit to anyone. Quarterly reporting does not solve the problem of providers using reporting periods ending in other than March, June, September and December.

Q. Can we reduce the present 120-day time period after the close of an accounting year that hospitals have to report?

A. The time period has to be related to the purpose, function, intended uses of the reports, volume of data elements required and certification requirements. Given the current HCFA 2552 cost reporting form, the 120-day time period is necessary for providers to close their financial records, determine all of the required statistics, determine the accuracy of the financial and statistical data, prepare schedules for audit and for the certified public accounting firms to perform their audits and issue their opinion on the statements. New York State requires that the New York State modified cost report contain an opinion by certified public accountants.

Q. Can we reduce the approximately 180-day time period which the fiscal intermediaries hold the data, perhaps through increases in their budgets?

A. The work requested of the Fiscal Intermediaries to perform on the cost reports should be reviewed to determine if there are any obsolete or outdated functions as well as just what the Fiscal Intermediaries should be doing to review the report forms. New York State can obtain usable data from approximately 300 providers within 8 to 9 months after the close of the cost reporting year; 120 days for hospitals to file, 90 days for the Fiscal Intermediaries to edit and prepare computer files. Budgets of Fiscal Intermediaries may need to be increased to provide additional staffing and computerization of the audit and reporting process.

Q. HCFA appears to spend an inordinate amount of time putting the data in reportable form. Can we reduce that time period?

A. The Fiscal Intermediaries should be required, as part of their desk audit functions, to put the data in reportable form. If the providers have not provided accurate information or left out required information, the data should be obtained from the provider. The New York State Uniform Reporting form is in computer input format. The Fiscal Intermediary enters the data and generates tapes of the data for the State and other potential users of the data. If the data is in reportable computer tape format when it leaves each Fiscal Intermediary, the data should be in HCFA usable format after the tapes have been merged from the various Fiscal Intermediaries without undue delay.

Q. Are there discrepancies between the data reported on quarterly reports (unaudited) and that reported on the annual report?

A. Yes. The audited report has been subjected to year end review by the provider with the year end being held open longer to obtain data relevant to the year just completed, accounts have been analyzed and schedules prepared for outside auditors, and certified public accounting firms have issued their opinions on the financial statements and reports. Unaudited quarterly reports contain data for a shorter period of time after the quarter ends, and accounts are not analyzed as thoroughly. Revenues and expenses are not matched to the same degree as they are in the annual reports.

Q. Can we simply promulgate the Annual Hospital Report developed by HCFA and released August 15, 1980? Is it still relevant?

A. No. The purpose, function and intended use of the data as well as the report format must be determined first. The Annual Hospital Report was essentially a uniform functional accounting document which was and still is incompatible with the objectives of hospital management. To provide the required information, duplicate accounting systems, at substantial cost, would have to be maintained. It contains a mass of administrative detail without meaningful benefit to the industry, government or the public. The reports mandated such an intense level of detail that information becomes too costly to generate, report, accumulate and utilize. The report also interferes with significant components of existing Medicare regulations and policies.

Q. Can either New York or California's reporting system be adopted for the nation as a whole?

A. First, it is necessary to document specific needs, then develop the reporting format and create the system to satisfy those needs. California's reporting system is a quarterly functional system which can not be converted to a responsibility reporting format. New York's reporting system is a responsibility reporting system used for reimbursement by third party payors which can not be converted to a functional reporting system. New York's reporting system accommodates the needs of payors, other than Medicare and Medicaid, so that only one report is prepared, not multiple reports for various payors. New York's reporting system accomodates all forms of hospital accounting formats in the State and is equivalent to the HCFA Form 2552. Therefore, it is reasonable to assume that any hospital in the country could complete the New York forms. This is not true for the California Cost Report.

HFMA

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

[illegible] SPRING ROAD
SUITE [illegible]
OAK BROOK, ILLINOIS [illegible]
TELEPHONE [illegible]

June 17, 1987

The Honorable Fortney H. Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C 20515-6348

Dear Mr. Stark:

We appreciated the opportunity to testify at the hearing on June 1, 1987, concerning financial reporting by hospitals and other institutional healthcare providers. The following responds to the questions included in your letter of June 8.

1. The data elements in the current cost report that are most obsolete, outdated, and burdensome are the Part A adjustments. These were mostly designed to minimize Medicare payment and are no longer relevant since most Medicare payment is based on prospectively established rates.

   We are concerned with reference to "a new uniform report" which implies an additional report would be required. This adds to the already heavy reporting burden of institutional healthcare providers. We favor a simplification and better use of the current Medicare cost report.

   A key objective of a revised reporting system should be decision usefulness of the reported data. We believe it is preferable, and more accurate, to report a few key items of information rather than creating voluminous detailed reports that can lead to inappropriate conclusions. For example, we believe Congress should know the overall fiscal condition of institutional healthcare providers, but do not believe detailed information about each type or source of income is necessary.

2. Timeliness of reports can be improved as outlined in our written testimony. Different end dates of hospital fiscal years are not an impediment to more timely reports. If quarterly reports are desired, it is possible to promptly compile annual data from all hospitals each quarter for the fiscal years ended during

the preceding 12 months. Quarterly reporting by institutional healthcare providers is undesirable because:

a. significant reporting burden would be added;

b. there is limited, if any, added value for formulation of public policy;

c. the reported data is harder to verify and independent verification would be unreasonably costly;

d. detailed work done by any organization to improve accuracy of annual financial reports is not practical to do quarterly. This interim quarterly data is therefore less accurate; and

e. many institutional healthcare providers (like many other businesses) divide their fiscal year into 13 four week periods rather than 12 monthly periods. Therefore, a quarter is not a uniformly available reporting period.

Government control of hospitals' fiscal years is not necessary. The IRS and SEC, for example, have not found it necessary to dictate fiscal years. In fact, a steady flow of data throughout the year facilitates prompt processing. A crush of data on a single date would add to cost and complexity for institutions and the government.

Institutional healthcare providers presently have 90 days to file their cost reports with a 30-day extension if needed. This time cannot be shortened significantly if accuracy is to be maintained. The institution's year end audit must be completed prior to completing the Medicare cost report. Adequate time to prepare and verify this information is essential. By simplifying the data to be reported, some time might be saved but timeliness is not a major objective of our recommendation for simplification.

We are unaware of any time consuming processing of data by the intermediary once it is supplied by institutional healthcare providers. Therefore, our view is that the intermediary work can be done in much less than the 180 days that intermediaries presently hold the data. We suggested in our testimony that 30 days for intermediary processing should be sufficient.

We also believe that 30 days for HCFA compilation of reports should be sufficient. We understand that presently data entry is not begun until a whole year's data is in hand. Furthermore, report formats and processing procedures are not done until that time. Several steps can be taken to sharply reduce HCFA processing time:

a. The data elements to be analyzed can be sharply reduced. In our testimony we suggested that analysis be limited to 30-50 items;

b. report formats and processing procedures should be established in advance, should be kept simple, and should be consistent from year to year; and

c. data entry should be done continuously as data is received.

3. While we cannot comment on the California report specifically, we are quite certain that there are differences between unaudited data and subsequently verified data. However, we doubt that the differences are material to formulation of sound public policy. A concern about minor differences can be further alleviated by:

a. focusing on relatively few, broad-based data elements;

b. reducing the differences between data reported to Medicare and data in the institutional healthcare provider verified financial reports; and

c. regularly analyzing the causes of any differences and improving the data collection procedures to reduce the differences.

4. We do not believe a "new uniform reporting system" is needed. The 1980 "Annual Hospital Report" is particularly inappropriate because:

a. the reporting objective of the data system was never defined;

b. the data elements were so detailed that a uniform accounting system would have been required to comply; and

c. the report was so burdensome that significant unnecessary cost would have been incurred.

It is for these reasons that Congress appropriately rejected this system in 1980.

We have not studied the New York or California systems in detail. However, it is quite apparent that these systems are excessively detailed, undesirably duplicative of the Medicare report, very costly, and have ill defined reporting objectives. In Mr. Ferman's testimony, he acknowledged that one of the principal users of individual institutional information is competing institutions. We question the desirability of putting individual hospital's financial data into a system that could be used for such nonpublic policy purposes.

Undue attention to individual institutional data can distort sound decision making. If individual exceptions are necessary, such arrangements can be made. Distortion of broad policy decisions to achieve targeted results often have other unintended and possibly undesirable results. Often such efforts add undesirable complexity and obscurity and make compliance difficult for everyone. Each institution has its own unique circumstances. Changes in policy interact with those circumstances in individual and often unexpected ways. Therefore, we believe policy decisions are best guided by broad-based analysis. This could include an assessment of the number of institutions in certain categories (such as teaching status, size, or location) that will likely be affected adversely. Targeting decisions based on individual institutions affected seems undesirable, however. A decision to use information about groups of institutions can simplify the provision of information, processing, and reporting that information.

Thanks for allowing us to provide our views. Please call Ronald Kovener (202-296-2920) or me (312-571-4700) if we can provide additional information.

Sincerely,

Richard L Clarke

Richard L. Clarke
President

RRK/mp/dvw

Chairman **Stark**. Let me give you a couple of things that occurred to me as a result of receiving some information from California hospitals, and see whether this is going to be an impediment to our pushing for this.

I received from perhaps I guess your organization, John, a list of hospitals in my congressional district. And a cover letter suggesting that they were all going broke.

Mr. **Ferman**. That wasn't from us.

Chairman **Stark**. Okay. Or something to the effect that they were all losing money. For some reason we weren't paying them enough.

I took the worst hospital, Fairmont. You would go a long way in northern California to find one with worse problems. It's a county hospital, so they ought to be doing charity and uncompensated care, and we, the taxpayers of the county, ought to be picking up the difference.

It showed a loss of maybe $400,000 and uncompensated-charity care, of maybe a million and a half. And now the Medicare part was maybe somewhat worse than that, but the overall, it wasn't bad. I suspect in these figures there were noncash costs, like depreciation. So you would look and say for a hospital that I would have expected to be out of business 10 years ago, they are limping along, and the costs to the county taxpayers for running our drug detox and other programs doesn't seem unreasonable.

Now, am I being misled even more by the reports than I am by the guy writing me saying the hospitals are going broke, or is this a danger that you all see that amateurs like me start to look at this data and say this doesn't look so bad? And if I get to the profit hospitals, they are cutting a fat hog, with 40-percent occupancy, making huge profits on everything. I say they don't need any help at all. They ought to be contributing to the other ones.

But these are the kinds of dangers that I think the industry sees in giving us a little bit of knowledge.

Mr. **Ferman**. There is a danger, but it is a danger that can be managed. And it is one that——

Chairman **Stark**. I know the AMA tried that. But do you have any other ideas?

Mr. **Ferman**. We are aware of the conclusions and, you know, from the Government perspective, from this committee's perspective, you are looking at the allowable costs in Medicare. And that is the basis of ProPAC's conclusions and GAO's and all the others relative to profitability.

What our uniform accounting system reports by a major payer are the full costs providing the services to that program. And in California, in the Medicare area, it is about 12½ percent difference between what Medicare allows and what are the full costs of providing those service. So that is what you see on those reports, not allowable costs but full accounting costs, not economic costs but full accounting costs.

You can cut it across by programs, Medicare, Medical, and all others. That's what you are seeing. So you have to make your assumptions or your conclusions based on the fact that you are looking at full accounting costs, not allowable costs.

Chairman Stark. Let's assume for a minute that we are going to have the capital debate again this year, and I am going to hear from the city of New York and other places that say we've got 99-percent occupancy and buildings that are about to fall down on our ears, and in California they are not earthquake proof, and we are going to have to abandon thousands of beds. And unless we reimburse them for capital, they will never serve another sick person again.

But I don't like capital reimbursement. So I sit here and say what if I looked through the same list and I find that there's a correlation between the intercity hospitals that are about to fall down and uncompensated care, or disproportionate share, and maybe even in teaching institutions.

So if we want to, we could just play what ifs on our Lotus 1, 2, 3, and say, what if we increased uncompensated care or disproportionate share or teaching, do we have the same effect, getting dollars to hospitals that we assume need assistance without loading all kinds of free capital on some little rural hospital that serves one Medicare patient and, therefore, gets 100 percent of its capital back.

I mean are we in danger of creating worse problems with all this information?

Mr. Ferman. I don't think so. I think that with a limited amount of dollars available, with the deficit and all the other factors, you are going to have to target realistically and you can't take it in the broad brush with the information we have now.

There are going to be winners and losers in that reality, and if we identify the disproportionate share providers in the large intercities, those who are associated with the large base of uncompensated care, then so be it. That's where the dollars have to go.

Chairman Stark. Anybody else want to comment on that?

Mr. Clarke. Let me make a comment about the uniform reporting and uniform accounting.

It is true that, in fact, the Medicare cost report itself is somewhat of a uniform report. And that hospitals without uniform accounting are capable of filling out that report right now.

My concern is when you get into a detailed report, such as the ones in New York and California, that you zero in on very, very specific data, you then have to have the accounting system geared to capture that data. And that starts to generate the cost and some of the concerns about mandating uniform accounting if we get into very, very specific data.

As I indicated in my testimony, part of our concern is that as you get into very specific defined data, the chance for error of that data is much greater.

As I indicated, the Financial Analysis Service report is produced with 32 elements of data from audited financial statements. And we feel that——

Chairman Stark. But yours is aggregated, isn't it?

Mr. Clarke. While, it's aggregated, it is also broken down by bed size and by region.

Chairman Stark. Yes. But not by specific hospital.

Mr. Clarke. The specific hospital can get a financial report from the system and it does comparisons.

The point is that the more detailed, or comprehensive the reporting requirements, the more accounting changes that will have to be made.

Chairman Stark. The data I have seen doesn't seem so voluminous. I am sure that what I am seeing is condensed from a larger report. But the problem is that you all are dealing with hospital management, right? So you've got a hospital financial officer and he wants to ask questions like, well, I have got a 60-percent Medicare base, and I've got a 82-percent occupancy and I've got this and I've got that and, therefore, I ought to be charging 3 percent more on this, and these guys understand all that, right?

Mr. Daub isn't going to ask me that. He is going to ask what about this hospital in Omaha? What's going to happen if we increase it? Well, you can ask it about San Francisco and I'll ask it about Omaha. [Laughter.]

But what I am saying is we are going to want to look in this book and say, well, how is my hospital doing. This one right here. And that's the difference. I would like to at least impress on you all is that we are often making political decisions and we have to get enough votes on the floor to pass whatever we're going to pass. And we really don't know who the winners and losers are.

In the aggregate, we might understand from reports like you're talking about that hospitals with a high percentage of charitable care benefit or don't benefit. But, we don't even know where they are. And that's what is so important to us because that's how, for better or for worse, our decisions are made.

If we have the members, we will make better decisions, or we would be less apt to make bad mistakes.

Mr. Clarke. I agree. Our statement advocates the redesign and simplification of the Medicare cost report which would give you specific data on each hospital.

Our concern is not to overload the data element so significantly that we would put a reporting burden back on the hospitals when they are already attempting to manage cost as effectively as they can.

The idea is to try to specifically identify what data is needed to make effective decisions and then only request that data.

As I was talking to my colleagues from New York and California, it appears that there is an awful lot of data that is being collected—more than the cost report currently is requiring. And a lot of the data is not really used for Government purposes.

Chairman Stark. Go ahead.

Ms. Scanlan. In New York State, we are on the verge of a change in that beginning in 1988, for a 3-year period, we will probably have a case payment system for all other payers in addition to Medicare. As a result, we will need to look at our cost reporting system in the aggregate to see if it still serves the purpose of the case payment system. But I would venture to guess that the kinds of dollars and the kind of cost center allocations that are collected would serve under a case payment system as well as under the current system we have as a per diem.

Mr. Chairman, I would just like to add that we agree with you that the kind of specificity of information needed on a hospital-to-hospital basis is very necessary. But I would also caution all of us that sometimes that makes decisionmaking even harder because we will clearly know the winners and the losers. And in the environment that we deal in, more clearly knowing winners and losers sometimes makes decisionmaking more difficult.

Chairman **STARK**. Well, I guess. People generally work on this committee because they are intrigued with it; the issues don't seem to change much. Also it might have a very meritorious effect on the Office of Management and Budget if we could prove our case somewhat more accurately. Because they tend to work it until it has cost about everybody 10 percent, 5 percent, 2 percent, whatever they are talking about because we have got figures from 3 or 4 years ago that show that there is too much profit. That may be. I mean I wouldn't want to quarrel with that and take a position I don't believe them.

But I would sure like to sort through a few examples to make sure, before you buy into that, there isn't something in this average that they're talking about that's really going to disrupt an awful lot of people.

And we don't have any real way of knowing that because the winners aren't in here sitting at that table testifying that they have too much.

I have yet to hear anybody but a loser. I have yet to have testimony from anybody who says, we're caught in a fat hog, and they won't pay us any more.

But somehow I suspect that may be out there. Do all three of you feel that it would be possible to simplify the reports that HCFA is getting now? For example, to get something that would be similar to the California format and still be useful to hospitals to handle without putting them into financial ruin and upsetting their entire data management system.

I say this without prejudice to the New York system. I have seen the California report. And I have looked at it without any idea of saying this is more than I need or less than I need.

But I am suggesting that because it seems to be working, and because nobody has suggested that this report alone accounts for the extremely high cost of the California operation overall, that maybe this would be a win-win situation if we could all work together.

Now, does that seem possible to all of the witnesses here?

Mr. **CLARKE**. One of the things that we have talked about is simplifying and revising the current cost report. Although the California hospitals are comfortable with, or at least knowledgeable of, the California system, nobody else is.

And as a result of that, it would be easier, I would think, to try to take something that people are already familiar with and modify that significantly to find the data elements that are necessary to make pertinent and informed decisions and then go forward.

Chairman **STARK**. I am going to let Mr. Daub inquire, and I——

Mr. **DAUB**. I am leaving, Mr. Chairman.

Chairman **STARK**. You're leaving.

Mr. **DAUB**. I have a question though.

Chairman **STARK**. OK. Why don't you proceed? Mr. Levin is here and he will keep the discussion going. I have to go.

Mr. Levin will assume the chair and we will proceed.

Mr. Daub. To me it is not a very philosophical kind of a thing. I think hospitals are under fire today, all kinds, big and little, rural and urban, and I think the biggest mistake Government makes all the time is trying to micromanage you. And here we go again.

You come and tell us you want a new form and you want more data and you want uniform data collection. Do you know what that means? Because when we get done doing that, it is going to be more complicated and more complex and more expensive to every single hospital, big and little, in New York and California and Nebraska. That's generally the tendency of the bureaucracy. It expands in ever increasing concentric circles. It doesn't want to justify its going out of business. It wants to keep justifying why it should manage more.

So it seems to me that we ought to be very careful. I think you are right. We are going to find out some things we don't want to know. I think GAO is going to tell us that we are putting too much money into disproportionate share. And that report will be out in a week or two. Then what are we going to do?

In reconciliation in the next 2 weeks or this year, are we going to take a bunch of money out of disproprotionate share if we find out we should? But we won't.

So I am not sure that more reports are going to tell us anything more than what we already know. Are we going to rebase, are we going to apply DRGs to nursing homes, you know? When will we decide that we are going to let hospitals that are inefficient close, fail, merge?

I think what is going to happen is, we are going to gather so much data that we will weight the system's money to the urban areas, to the big city, to the pockets of poverty, and the rural systems and the places where the population is spread out and there are fewer people who are going to ultimately end up suffering.

Because we keep good census tracts and good data on every program I know, from bridges and roads to health care, we tend to put the money where the statistics are the most alarming. So we manage by statistics, and we end up in a way diluting or shrinking or gutting the health care delivery systems in almost every other place in the country, be it Appalachia or be it Midwest or wherever.

I think there are rural parts of New York and California as well that will suffer badly from too much of a focus on where the statistical problems are in our health care delivery system.

So I guess that's what I worry about. I don't like to see hospital systems give me averages like we're 43 percent occupied or 66 percent occupied or 82 percent occupied unless we want to preempt all States and issue certificates of need from Washington. How would you like that?

Any comments? After I listened to Mr. Stark for an hour, I decided that maybe we are going—maybe this would be taking us down the wrong direction. I mean aren't you a little concerned about that, that we could end up with so much micromanagement that we really won't like even though we don't like what we're doing now?

I mean, you know, Morris West wrote a book called the Devils' Advocate. I just thought I'd throw that out, and see if there is any opposite reaction, and then we could just plow down the other road.

Ms. SCANLAN. I think we would agree that while data is essential for understanding what's going on, we don't always make decisions based on the individual hospital's needs or group needs. That's what I was referring to earlier.

You are right. In New York State, we have a major part of our State which is rural. We have 76 hospitals out of our 280 which are categorized as rural hospitals and over 100 hospitals that receive an adjustment to their Medicare rates of payment because they serve a disproportionate number of low-income patients. We are very concerned about those hospitals and their ability to continue to function and to serve their communities which have very widespread population bases, and are needed where they are, despite their smallness.

The data that one collects about those hospitals don't always indicate the same kind of need that one collects about intercity hospitals where needs are great. And you are right, to have a tendency to monopolize the available funds.

So what I guess we believe in New York State is that we need the data to understand what is going on so that we can step back and make informed decisions about ways of distributing the money so that we know who the winners or losers are. And when hospitals do go bankrupt or do need to consolidate, we know it ahead of time. We don't necessarily know that now. We make decisions now that have unanticipated consequences for the individual hospital because of the data that we have being so old or not necessarily adequate.

Mr. FERMAN. I think what may happen when all of this is said and done is that we won't more data but we could have less data.

What we are arguing for is timeliness of relevant data, uniform data. And what we are arguing for is the revision or streamlining of the Medicare cost report, which is currently a relic, a dying reimbursement culture. It no longer serves a purpose.

Mr. DAUB. About 3 or 4 years behind all the time.

Mr. FERMAN. That's right. What we would like is a system that maybe within 10 to 12 months after the close of an accounting year or fiscal year, we would get a good sense of what's happened in terms of types of hospitals, the areas in which they serve, their condition, their performance. In California the data cut both ways. It shows some significant problems for rural hospitals, and there's legislation to address that, and it also shows problems for intercity portion of share providers.

And, yes, I would disagree with the movement towards micromanagement. In California, we are moving in a different way.

Mr. CLARKE. I would agree also that micromanagement is something we want to try to avoid. But the current data that is available from the Medicare cost report is not only not timely, but it is erroneous because the costs are defined for payment minimization. As a result, what we have is bad data. Probably no data is better than bad data. The data is 4 years behind, so we are getting data, but you are right, it doesn't reflect changes in the formulas.

And the concern is making policy decisions based on data that is out of date and inaccurate. We would like to see a revised, simplified cost report that would have data that we could all embrace as being accurate, and that would eliminate a lot of the smoke.

Mr. DAUB. Have you written a form? Have you got a data base or a——

Mr. CLARKE. No. But we certainly have a group of people that would be more than happy to work with you all to do that.

Mr. DAUB. Gee, wouldn't it be great if everybody on the outside of this 10-mile square, which is bound by reality, you've heard that before, designed a form that the Government could use instead of letting us do it inside here, where we maybe don't have all the ideas about how to put the right kind of a question to get the right kind of an answer.

Mr. CLARKE. Until last year, I was the CFO of a hospital in Colorado and had to deal with the cost report as it is currently configured. And a lot of times I did not pay much attention to the data simply because it was so meaningless as far as what I needed to be able to manage the organization.

Mr. DAUB. Mr. Chairman, I have nothing more.

Mr. LEVIN [presiding]. Thank you. I assume we will have to do it together.

You know, I am new to the subcommittee, but on almost every problem I have some discussion on and meet with various groups about, the ancientness of the data is always raised. People use it depending on what side they are on.

Mr. DAUB. The chairman knows, when we are not sure of something, we mandate a study. We put a date on it like 1989, and then we have hearings between now and 1989 and we keep saying we are getting a report on that. And by the time we get to that data, of course, it's not ready, so instead we beat up on whoever we assigned to do the report because they don't have the report ready. And in every reconciliation bill in between, we've changed the formulas. And it is a problem.

And the answer to a lot of our health care subcommittee work might very well be in the end simply agreeing on being more functional, and I would argue, probably more streamlined. I don't know that we need to have all of the data some people think we need to have.

To the extent we could do that and expedite the reporting to us, such that we are only operating a year behind, instead of 3 and 4 years behind, it would help an awful lot.

I have no more questions, Mr. Chairman.

Mr. LEVIN. It's confusion when we have a lot of data that's out of date.

Well, thank you. I am sorry I missed your panel, but Karen has taken good notes, and I will be brought up to date.

Thank you.

Mr. DAUB. I have got to go.

Mr. LEVIN. The next panel—you have to go, all right.

The chairman and I agreed that we would continue. So anybody who brought a brown bag is lucky. Those who did not will have to wait.

Our next panel will consist of Toby Edelman, National Citizens Coalition for Nursing Home Reform; Jerry Bryant, Association of Health Facility Licensure and Certifications Directors; Paul Willging, American Health Care Association; and Michael Rodgers, American Association of Homes for the Aging.

Welcome. We will wait just a minute for those who are coming in to be seated and those who are leaving to have left.

You know our procedure. Some of you, if not all, are veterans of these efforts. Your full statements will be printed in the record and we will hope that you can summarize your statement, as you know, for those members who cannot be here. There usually are members of their staff here so we will all benefit from this opportunity.

My colleague, Jim Moody, was perhaps on the same airline as I was and therefore automatically delayed. But this is not a hearing on airline problems.

All right, so Toby Edelman, you are going to begin.

Jim, we are just starting with panel number two, if you want to join me closer to the firing line.

Thank you. Toby Edelman.

STATEMENT OF TOBY EDELMAN, BOARD OF DIRECTORS, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Ms. EDELMAN. Thank you. My name is Toby Edelman and I am a member of the board of directors of the National Citizens Coalition for Nursing Home Reform.

On behalf of more than 300 member groups in 46 States the coalition commends you for your commitment to nursing home reform this year. While serious problems persist in nursing homes, a blueprint for reform also exists. In March 1986, following more than 2 years of intensive study, the Institute of Medicine published a comprehensive report on nursing home reform. That report endorsed principles of reform that had been set out over the last decade in numerous reports and investigations.

Following release of the IOM report, the coalition convened and coordinated a series of over 30 discussion sessions in which the IOM recommendations were thoroughly reviewed and further developed. This effort by a broad ad hoc coalition of 20 national organizations representing consumers, providers and health care workers and professionals led to the development of 12 public policy position papers that were printed in the Campaign for Quality Care in Nursing Homes.

More than 55 national organizations have now endorsed these position papers. We have given a copy of them to your staff.

Broad public interest in nursing home reform has never been more serious or more united. Nursing home reform must address three areas: the requirements that participating providers must meet; the methods State agencies must use in conducting survey and certification activities; and the enforcement mechanism States and the Federal Government can use to deal with facilities that are not in compliance with requirements.

I would like to highlight several key issues in each of these areas. With respect to nursing home requirements, Federal law must make plain that nursing homes exists to serve residents. Current regulations on residents' rights must be strengthened and comprehensive resident assessment must be required.

Staffing in nursing homes also needs to be strengthened. Nurse aide training must be mandated at the Federal level. Facilities should be permitted to employ as aides only individuals who are both trained and competent to do the tasks to which they will be assigned.

Nurse staffing must be federally upgraded. While States should establish staffing requirements in accordance with Federal regulations, they should also have the authority to require facilities to change or increase their staffing as necessary to meet their specific residents' needs.

The coalition endorses qualified registered nurse coverage around the clock in all facilities, and we support no less than H.R. 2270's proposal for 24-hour licensed nursing services and coverage by a registered nurse at least 8 hours per day 7 days a week.

Professional services, particularly social services and mental health services, need to be improved. Improvements in the survey and certification process are also critical to meaningful nursing home reform. A number of important IOM recommendations in this area, such as the requirement of validation of survey protocols and the requirement for multidisciplinary survey teams appear in many of the bills and should be incorporated this year.

In one area we disagree with the proposed legislation. We do not support standard and extended surveys. Previous recommendations for a two-tier survey system have meant abbreviated surveys that look quickly at the surface for glaring problems. Nursing home residents need greater protection than that.

The annual survey must be a promise of meaningful review of each facility's compliance with all Federal requirements for participation. Surveyors must, of course, devote the greatest portion of their time and attention to issues of resident health care, and abbreviated survey carries the danger of ignoring equally important issues of quality of life and residents' rights.

The final critical area for reform is enforcement. Good standards and good surveys will mean very little if there is not effective enforcement. States must have a range of enforcement options and strategies to use with facilities that are out of compliance. The options must vary with the severity and frequency of deficiencies and more severe sanctions must be available for use against chronic or repeat violators.

Intermediate sanctions should include actions to correct deficiencies and to protect the health, safety, welfare and rights of residents. States should have additional sanctions to use in place of decertification where other action would be effective to remove the jeopardy. Some deficiencies that place residents in serious jeopardy can be promptly corrected without requiring removal or residents to other facilities.

Coordination between State and Federal Government is also essential. A State's use of an intermediate sanction that is leading to facility compliance can be fatally undercut by the withdrawal of Federal funds. H.R. 2270 calls for coordination of Federal and State responsibilities in a constructive manner.

We believe that changes in public policy are best brought about in a public forum with full public debate. We urge you not to include any provision allowing the Department to bypass the Administrative Procedures Act, as H.R. 2270 does.

In conclusion, nursing home reform demands many changes in current practices involving nursing home requirements, survey and enforcement. Needed changes have been thoughtfully evaluated and tested over the years and consensus exists now as never before to enact these reforms this year. We urge you to use this opportunity to pass comprehensive nursing home reform legislation.

We thank you for your commitment to reform and stand ready to assist you in any way that we can.

Thank you.

[The statement of Ms. Edelman follows:]

TESTIMONY OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Presented by

Toby Edelman, NCCNHR Board of Directors

to the

Subcommittee on Health, House Ways and Means Committee

June 1, 1987

On behalf of more than 300 member groups in 46 States, the National Citizens' Coalition for Nursing Home Reform commends you for your commitment to nursing home reform in the 100th Congress.

While serious problems persist in nursing homes, a blueprint for reform also exists. In March, 1986, following more than two years of intensive study, the Institute of Medicine published a comprehensive report on nursing home reform. That report endorsed principles of reform that had been set out over the last decade in reports, investigations, and hearings by State and federal committees and organizations.

Following release of the IOM report, from June, 1986 to April, 1987, NCCNHR convened and coordinated a series of over 30 discussion sessions in which the IOM recommendations were thoroughly reviewed and further developed. This effort, by a broad ad hoc coalition of twenty national organizations representing consumers, providers and health care workers and professionals, led to the development of twelve public policy position papers that were printed in the Campaign for Quality Care in Nursing Homes. More than 55 national organizations have now endorsed these position papers, copies of which we have given to your staff.

Broad public interest in nursing home reform has never been more serious or more united. The time has come to enact comprehensive nursing home reform legislation.

Nursing home reform must address three areas: the requirements that participating providers must meet; the methods State agencies must use in conducting survey and certification activities; and the enforcement mechanisms States and the federal government can use to deal with facilities that are not in compliance with requirements. H.R. 5712, introduced by Mr. Stark last year, addressed each of these areas. In developing legislation this year, we suggest that you also review and incorporate provisions of Mr. Dingell's and Mr. Waxman's bill, H.R. 2270, and Mr. Mitchell's bill, S. 1108.

I would like to highlight several key issues for federal legislation this year.

Nursing home requirements

Federal law must make plain that nursing homes exist to serve residents. Strengthening residents' rights and resident assessment requirements gives meaning to the focus on residents:

Residents' rights are obviously a critical area for residents. Federal law should underscore that citizens who live in nursing homes retain all their rights of citizenship, their rights as Medicare beneficiaries and Medicaid recipients, and personal rights, as well as rights as residents of institutions. Facilities and their staffs must be required to advise residents of these rights and to assist residents in exercising their rights.

In drafting specific rights, Congress must ensure that all current regulatory rights are retained, giving special attention to the issues of access (to visitors and ombudsmen, among others), transfer, and nondiscrimination based on source of payment. H.R. 2270's protections in the area of psychotropic drugs should also be included in your bill.

Resident assessment is critical to assuring that each resident receives his/her full entitlement to high quality care in the facility. The Secretary must design and test a resident assessment system that includes a minimum data set of core elements, common definitions and guidelines for facility use.

Registered nurses trained to conduct assessments must coordinate a comprehensive assessment of each resident and the assessment must form the basis for care planning for the resident. S. 1108 sets out resident assessment in this manner.

Staffing in nursing homes needs to be strengthened:

Nurse aide training must be mandated at the federal level. Facilities should be permitted to employ as aides only individuals who are both trained and competent to do the tasks to which they will be assigned.

Federal law should require the Department of Health and Human Services to establish specific state plan requirements for a program for the training and competency testing of new and currently-employed nurse aides. Initial training must include both classroom and clinical instruction and must be provided either before or within the first two months of employment. Trainees should receive salaries during their training and should be protected by fair testing and appeal rights. S. 1108 incorporates many of these recommendations in its section on aide training.

Nurse staffing must be federally upgraded. Standardized staffing must be based on resident acuity levels and care needs, with staffing levels established for each shift and for each staff level (registered nurses, licensed practical nurses and nurse aides). While States should establish these staffing requirements, in accordance with federal regulations, they should also have authority to require facilities to change or increase their staffing as necessary to meet their specific residents' needs.

NCCNHR endorses qualified registered nurse coverage around the clock in all facilities. We support no less than H.R. 2270's proposal for 24-hour licensed nursing services and coverage by a registered nurse at least eight hours per day, seven days per week.

Professional services provided by nursing homes also need to be improved:

Social services by qualified social services providers must be required. Social services needs include resident and family adjustment to institutional living and consultation and assistance to nursing home workers. This strong IOM recommendation for improved social services in nursing homes is proposed in S. 1108.

Mental health services are often totally lacking in nursing homes. Mental health assessment and services, as appropriate, must be made available in long-term care facilities.

Survey and certification

Improvements in the survey and certification process are critical to meaningful nursing home reform. H.R. 5712, H.R. 2270 and S. 1108, to varying degrees, all incorporate a number of important IOM recommendations in this area:

*requiring the annual survey to be conducted between nine and fifteen months after the previous survey, in order to strengthen the element of surprise;

*requiring validation of survey protocols;

*requiring State agencies to have adequate procedures and staff to handle complaints;

*requiring comprehensive initial and continuing training of surveyors;

*requiring survey teams to be multidisciplinary;

*requiring coordination of State survey agencies with other appropriate agencies, such as Medicaid fraud control units and long-term care ombudsmen;

*strengthening federal validation surveys;

*requiring the Secretary to develop and implement criteria and procedures for evaluating plans of correction; and

*requiring public disclosure of the results of surveys and inspections.

We encourage you to incorporate all of these provisions in your new legislation.

However, we disagree with the concept of standard and extended surveys appearing in H.R. 5712, H.R. 2270 and S. 1108. Previous recommendations for a two-tier survey system have always meant abbreviated surveys that look quickly at the surface for glaring problems. Nursing home residents need greater protection than that. The annual survey must be a promise of meaningful review of each facility's compliance with all federal requirements of participation. Surveyors must of course devote the greatest portion of their survey time and attention to issues of resident health care and well-being. An abbreviated survey carries the danger of ignoring equally important issues of quality of life and residents' rights.

Extended surveys serve no useful role. First, surveyors already have authority and responsibility to extend their examination of a facility if serious problems are found. In addition, the availability of extended surveys could be interpreted to mean that no enforcement action may be undertaken after a standard survey, no matter how life-threatening the situation. This built-in delay could undermine the State's ability to initiate prompt enforcement activity after critical problems were found.

Enforcement

States must have a range of enforcement options and strategies to use with facilities that are out of compliance with nursing home requirements. The options must vary with the severity and frequency of deficiencies, and more severe sanctions must be available for use against chronic or repeat violators. Intermediate sanctions should include actions to correct deficiencies and/or to protect the health, safety, welfare and rights of residents.

Last year's bill, H.R. 5712, would have required termination of a provider contract if immediate jeopardy threatened residents' health and safety. We believe that termination should not be the sole state sanction. States should have additional sanctions to use in place of decertification where other action will be effective to remove the jeopardy. Some deficiencies that place residents in serious jeopardy can be promptly corrected without requiring removal of residents to other facilities. Since transfers of residents involve life-threatening danger, such transfers should be sparingly demanded and other remedies should be used when possible to secure facility compliance with requirements.

Coordination between State and federal governments is also essential for effective enforcement. A State's use of an intermediate sanction that is leading to facility compliance can be fatally undercut by the withdrawal of federal funds. H.R. 2270's provision "Continuation of Payments Pending Remediation" calls for coordination of federal and State responsibilities in a constructive manner.

Nursing home reform demands many changes in currect practices involving nursing home requirements, survey and enforcement. Needed changes have been thoughtfully evaluated and tested over the years. Consensus exists as never before to enact these reforms this year. We urge you to use this opportunity to pass comprehensive nursing home reform legislation in this Congress. We thank you for your commitment to reform and stand ready to assist you in any way we can.

Thank you.

Mr. **Levin**. Thank you very much.
Mr. Bryant.

STATEMENT OF JERRY W. BRYANT, PRESIDENT, ASSOCIATION OF HEALTH FACILITY LICENSURE & CERTIFICATION DIRECTORS

Mr. **Bryant**. Mr. Chairman, I am Jerry Bryant. I am director of the Quality Standards Division, Bureau of Long Term Care of the Texas Department of Health. I am currently serving this year as president of the Association of Health Facility Licensure and Certification Directors, which is an affiliate organization of the Association of State and Territorial Health Officials, ASTHO.

I come today, however, to represent the views of the individual state licensure and certification directors whose daily responsibility includes the survey and certification of Medicare and Medicaid nursing care facilities. Members of this Association have reviewed legislation that was proposed in the 99th Congress. We have reviewed some of the legislation that has been proposed in this, the 100th Congress.

Based on our long experience in this program—we have been doing this for 20 years—we welcome the opportunity to provide some comments on legislation which we feel represents a timely, necessary and important evolutionary step that will give a new sense of direction and purpose for the manner in which we assure that quality health care services are available to our citizens in need of nursing home services.

We did submit a written response. However, there are a few points I would like to emphasize. On previous legislation, the Health Care Financing Administration has taken the position that no new statutory authority is required, rather that the Secretary's authority to promulgate regulations would be sufficient to implement the Institute of Medicine report.

Our past experiences have demonstrated a marked reluctance or unwillingness on the part of HCFA to undertake timely regulatory change and our recent experience with the implementation of a new long term care survey process reenforces that belief.

Although this new PaCS survey system, as they know it, is the first real change in the 20 years of the Medicare and Medicaid program, it was accomplished without an open public comment period that provided for meaningful input. As a result, that system has some problems and it has been the subject of an adverse determination by a Federal court.

We believe that the Congress needs to give the Secretary specific statutory direction in the matter of nursing home regulatory standards. We feel it would be most appropriate if such determinations are made through the rule making process with proper publication in the Federal Register.

The matter of regarding the surveys, the standard and extended surveys, we would have to review what that protocol would be. We are concerned that in other legislation it says that we should not do a survey more frequently than every 9 months. We think that there are those situations where a survey would be required earlier than the 9-month period. We certainly would not want to go beyond 15 months between conducting surveys.

In one of the legislation, there is a requirement that we conduct a survey within 2 months after a change of administration or management. We do not feel that the funding that we customarily have would be sufficient to allow for that and such activity should remain as discretionary with the State survey agency to do as they deem necessary.

We are really concerned about some administrative penalties that have been proposed for inadequate State survey performances. The Health Care Financing Administration does have and exercises the authority to deny Federal financial participation in Medicare and Medicaid when facilities are found to be improperly certified either procedurally or interpretively.

The proposed penalty formula would severely restrict the ability of the State survey agency to continue to conduct appropriate certification activities. We firmly believe that the State survey agencies have been, are, and will continue to make dedicated efforts to survey and assure compliance with Federal regulatory requirements. If Federal validation surveys suggest less than acceptable State agency performance, there should be a triggering mechanism for increased Federal managerial and administrative assistance to the State survey agency, not the imposition of a fiscal penalty that would effectively cripple the agency and preclude its improvement. The amount of money paid for the survey and certification activities is a very small fraction of the total Medicare and Medicaid benefits.

Mr. Chairman, we commend you and other sponsors for the commitments that they have made and that are embodied in this proposed legislation. I pledge our support, both on an organizational and individual basis, and assistance as you, the Subcommittee, and the larger committee and the Congress further study these issues.

Thank you very much.

[The statement of Mr. Bryant follows:]

STATEMENT OF JERRY W. BRYANT, PRESIDENT, ASSOCIATION OF HEALTH FACILITY LICENSURE AND CERTIFICATION DIRECTORS

Thank you Mr. Chairman and Members of the Subcommittee. I am Jerry W. Bryant, Director, Quality Standards Division, Bureau of Long Term Care, Texas Department of Health. I am currently serving as President, Association of Health Facility Licensure and Certification Directors, an affiliate organization of the Association of State and Territorial Health Officials (ASTHO).

I have come today to present the views of the individual state licensure and certification directors responsible for the survey and certification of Medicare and Medicaid nursing care facilities. A member of this Association was a member of the Institute of Medicine Committee on Nursing Home Regulation and many of the states participated in either providing data, in work groups or in on-site visits by the Institute staff and committee during their study. Members of the Association have reviewed proposed legislation of the 99th Congress and have had contact with some Congressional staff members preparing legislation for the 100th Congress. We are aware that several bills have been introduced this year including those by Senator Mitchell, Representatives Waxman, Dingell, Pepper and Stark. These, and other members of the Congress should be commended for their initiative in addressing a very complex and sensitive issue. For the past 20 years, we have employed professional staff to conduct inspections of the country's Medicare and/or Medicaid certified nursing homes in accordance with established Federal criteria. Based on our long experience in this program, we welcome this opportunity to provide written comments which we feel represents a timely, necessary and important evolutionary step that will give a new sense of direction and purpose for the manner in which we assure that quality health care services are available to our citizens in need of nursing home services. While we strongly endorse most of the provisions, we are persuaded that certain additional comments are in order and are hereby offered for your consideration.

We strongly object to the position taken by the Health Care Financing Administration on previous bills that the majority of the proposals can be accomplished without statutory changes, but through the Secretary's authority to promulgate regulations beyond those already included in the statute. Our past experiences have demonstrated a marked reluctance or unwillingness on the part of HCFA to undertake timely regulatory change and our recent experience with the implementation of the new long term care survey process reinforces that belief. We note that the new survey process represented the greatest change in the way nursing homes are surveyed that had occurred in the last twenty years. Such a drastic change was accomplished, via fiat, and without an open public comment period that provided the opportunity for meaningful input. As a result, we are working with a system that is significantly flawed and has recently been the subject of an adverse determination by a federal court. We believe that the Congress needs to give the Secretary specific statutory direction in the matter of nursing home regulatory standards. Since this legislation will be charting the course for the future, we feel that those areas wherein the Secretary is charged to establish guidelines, standards and criteria must only be done through a very open and public process, wherein public comments can be submitted and must be considered before final determinations are made. We feel it most appropriate that such determinations are made through the rule making process with proper publication in the Federal Register. Failure to provide such a process only invites the development of administrative directives that are not sensitive or responsive to the many years of experience that our members have from being direct, on-site surveyors and regulators of nursing care facilities.

We strongly support the concept of standard and extended surveys assuming that suitable survey protocols will have been developed. However, we are concerned with the requirement that each nursing facility would be subject to an unannounced standard survey no more frequently than every nine months and no less frequently than every fifteen months. Under certain circumstances, it may be appropriate, based upon information known to the state survey agency, to do an unannounced survey earlier than nine months from the last such survey. In our experience, complaints filed with the state survey agencies often identify and trigger the need for a survey of the facility that is not limited to the investigation of the complaint itself. In addition, we are concerned with the requirement that a standard survey would have to be conducted within two months after any change in administration or management of a facility. Such management changes are not infrequent and we do not feel that our staffing levels could regularly permit such frequent visits. We recommend it be discretionary with the state survey agency as to whether or not they identify the need for a survey based upon changes in administration, management or ownership.

We are seriously concerned about the administrative penalties that are proposed for inadequate state survey performances. The Health Financing Administration currently has, and exercises the authority to deny federal financial participation (FFP) in Medicare and Medicaid when facilities are found to have been improperly certified either procedurally or interpretively. This federal "look-behind" authority is currently the subject of numerous appeals and often results from interpretive differences between state survey agencies and the Health Care Financing Administration—which further reinforces our recommendation for additional statutory and regulatory clarification of many of the provisions contained in this bill. The proposed penalty formula would severely restrict the ability of a state survey agency to continue to conduct appropriate certification activities. We firmly believe that state survey agencies have been, are and will continue to make dedicated efforts to survey and assure compliance with federal regulatory requirements. Federal validation surveys, suggesting less than acceptable state survey performance, should trigger increased federal managerial and administrative assistance to the state survey agency, not the imposition of a fiscal penalty that will effectively cripple the agency and preclude its improvement.

We also note proposals to put the states at risk financially if an intermediate sanction is imposed and the facility does not come into compliance during the three month period of that sanction. We feel this is an inappropriate approach. When a facility is found not to be in compliance, but its noncompliance does not immediately threaten the health and safety of its residents, the imposition of an intermediate sanction short of termination appears to be an appropriate strategy. In such a case, the state, in addition to identifying the items of noncompliance, would receive from the facility a Plan of Correction to remedy those identified defects. Further, the state would be responsible for properly monitoring the facility during the period of imposition of the intermediate sanction. While the state can assume its responsibility, it nonetheless requires the facility to operate in a good-faith relationship. If, during or at the end of the period of the intermediate sanction, the facility is found to be unable or unwilling to remedy its regulatory deficiencies, it does not seem appropriate to penalize the survey agency for such a failure. Rather, the penalty should rightly be against the facility by means of denial of FFP for the support of the Medicaid patients in the facility during that time frame. We strongly urge reconsideration and further study.

References to surveyor inconsistencies have been made and language proposed to mandate the states to address this issue. While we recognize that there is inter-observer variation at the state level, we would also suggest the problem exists at the national level. Since the Medicare/Medicaid program is essentially a national program with signficant federal financial commitment, we recommend that the Secretary be charged to identify areas of inconsistency and to develop and assist the states in implementing programs to reduce such inconsistencies. To leave such responsibility at the state level does not address the greater concern.

We recommend that the authority granted to the secretary to grant waivers regarding registered nurse services and Life Safety Code requirement be re-evaluated. Other proposals including HR-2270 requires the state to perform all other certification activities except for state operated facilities. We recommend that the states be given this waiver authority since the state survey agencies, utilizing other available state agency resources, are in the best position to make informed decisions on these potenial waiver requests subject to Federal review and "look behind" authority.

We support the concept relating to the preadmission screening and review for mentally ill and mentally retarded residents to assure that they will receive reasonably appropriate placement in a health care setting designed to meet their needs. However, we strongly urge the Subcommittee to reconsider the discriminatory manner in which FFP would be denied for certain services on behalf of such persons. If mentally ill or mentally retarded individuals need certain active treatment services, we feel there should be a federal contribution for the provision of those services if that individual otherwise qualifies for or needs the nursing services associated with a nursing care facility. To further assist us in this matter of conducting preadmission reviews of mentally retarded and mentally ill individuals, we recommend that the Secretary be required to publish specific criteria for screening these individuals and that there be a sufficient public comment period on the proposed criteria prior to their final promulgation.

We commend the proposal to eliminate the mandatory conduct of the inspection of care process separate from the survey and certification activities. At the same time, we support the proposal to permit states to continue to do inspection of care activities at their discretion. We have previously commented on and supported the requirement for preadmission screening of mentally retarded and mentally ill individuals. We would also suggest that preadmission screening authorization for Medicaid reimbursement should be applied to all nursing home residents.

In summary, Mr. Chairman, we commend you, and other sponsors for the commitments you have made and which are embodied in this proposed legislation. We believe it represents a sincere desire on your part to address the needs of our elderly population in need of certain institutional health care services, and we believe that the legislation, as proposed, represents a great step forward. We sincerely appreciate the opportunity to provide these comments. I am prepared to pledge our organizational and individual support and assistance as you, the Subcommittee, the larger Commitee, and the Congress further debate these issues.

Mr. LEVIN. Thank you very much. Dr. Willging.

STATEMENT OF PAUL R. WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, Mr. Chairman.

It is a pleasure to appear before this committee and you, Mr. Chairman, to talk about nursing home quality of care and nursing home reform. I think it is clear from all the literature and all comments that the nursing home industry has made dramatic improvements and strides over the past 15 years. Some would argue that we had no way to go but up.

Clearly Senator Frank Moss 15 years ago galvanized public opinion by pointing to some clear and indisputable problems the industry experienced. I think the Institute of Medicine study referred to by Ms. Edelman recognized the improvements that have been made and indicated that there is still a ways to go.

I am encouraged, however, that Tom suggested that we had moved to a new plateau. The biggest problems we faced in years past were problems of quality of care. We are now talking, however, about an equally important but different concept: quality of life in nursing homes; the dignity of the patient; resident assessment; the type of care that is provided; the privacy and the rights afforded to those residents.

Even since the Institute of Medicine study was published, additional progress has been made. The Health Care Financing Administration has not only put in a new review process called the PaCS system, but has enhanced its enforcement procedures as well. A new "look-behind" authority, fast track terminations, intermediate sanctions are all new tools now available to the State and the Federal Government.

But I would agree with Ms. Edelman that perhaps the most significant event since the publication of the Institute of Medicine study was the development of what are referred to as the consensus papers, the 12 discreet analyses and recommendations which encompass the basic thrust and the underpinnings of the Institute of Medicine study. The two paramount issues, I think, within those consensus documents are what is the agenda as yet unaccomplished, and what is do-able now?

I think this consensus activity, the coalition of professionals, of providers, of consumers that came together and said, let us in fact agree on the critical elements of the IOM study, marks a watershed in terms of nursing home reform and legislative proposals.

I think the concensus is an improvement, clearly, over all of the legislative proposals that have been made to date. It suggests an understanding of the realities of long-term care while at the same time not diminishing the need for continued progress.

For example, in the area of sanctions, it recognizes, as we do in the industry, that as long as there are facilities who choose to emphasize criteria other than patient care we do need sanctions, effective sanctions. But it also recognizes the fact that it is the State role to implement those sanctions. The Federal role is oversight to make clear to the States what their responsibilities are, to make sure that the States do fulfill those responsibilities, but not to attempt to do it for the State.

In the area of staffing, it was recognized that the key criterion in terms of the level and amount of staffing in a facility is the needs of the patient. We are trying to move away from arbitrary rules and procedures and processes applicable to each and every facility. There is no generic nursing home. There is in this land a great number of nursing homes, each of which differ because its patients differ. Staffing should be based on the needs of the patient rather than on any arbitrary and capricious guideline.

Finally, and most critically, the consensus documents recognize that if we choose to improve the care provided residents in nursing homes, we as a Nation cannot afford to hold out false promises. We must provide the resources whereby we enhance those standards.

I think we have recognized that the increased levels of reimbursement are not sufficient in terms of improved quality of care, but they are certainly necessary in many regards.

In closing, I would urge that the standards that this committee and the Congress decide upon are appropriate with respect to long-term care. Let us make sure we do not hold out those false promises. Let us make sure we are at the same time willing to pay for whatever it is we think is appropriate.

Thank you, Mr. Chairman.

[The statement of Mr. Willging follows:]

ALTERNATIVES FOR QUALITY IN NURSING HOMES

by

PAUL R. WILLGING, PH.D.

before the

SUBCOMMITTEE ON HEALTH

of the

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

June 1, 1987

Marie Infante

Good afternoon, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest association representing America's long term care providers. AHCA's membership exceeds 9,000 long term care facilities which care for about 900,000 residents each day.

The quality of long term care has come a long way in the past 15 years. Fifteen years ago, Senator Frank Moss, Chairman of the Special Committee on Aging, held a series of Congressional hearings that indicated serious problems in the provision of long term care in nursing homes. Most of the problems aired by Senator Moss and the Special Committee are now, thankfully, behind us. Nursing homes have made tremendous progress in providing competent basic health care and in assuring safe and sanitary facilities.

In February 1986, the Institute of Medicine (IOM) of the National Academy of Sciences issued an important report, Improving the Quality of Care in Nursing Homes, which reflected two years of study by experts in long term care. The study revealed that while nursing home providers have made great strides in delivering quality care, room for improvement still remains. IOM concluded that nursing home standards should be rewritten, the federal and state inspection process should be overhauled, and the enforcement of standards should be strengthened. With recommendations that have been found to be realistic and responsible, the IOM report has become an agenda for legislative and regulatory reform.

The American Health Care Association applauded the Institute of Medicine study when it was released. The study thoroughly examined a myriad of issues involved in the state and federal regulatory system and came up with common sense and progressive recommendations, setting a framework for action.

The year since the IOM report was released has been a watershed for nursing home quality and for enforcement of federal and state regulations. The Health Care Financing Administration has refocused its survey and certification process. Nursing home inspectors in every state have learned to orient their surveys away from paperwork and toward the actual care delivered to nursing home residents and the outcome of that care. Surveyors are interviewing residents in order to learn if the quality of their care is acceptable and whether they are satisfied with their nursing home.

This new survey system has led to tough, detailed, patient-oriented surveys. Facilities that appear clean and keep good records are being told that that is not enough. If patients are becoming less ambulatory, developing infections or show other signs of what surveyors call "negative outcomes," the facility is finding itself in trouble.

HCFA has also put into place a comprehensive enforcement system to deal with providers that do not meet program requirements. No longer may state survey agencies dawdle while they try to convince a provider to improve care and services. If any condition of participation is out of compliance, the provider must be terminated from the Medicare or Medicaid program within 90 days. If patient health and safety is placed in jeopardy, a termination action must take place within 23 days, 5 days in federal "look-behind" situations. In the first year these procedures were put in place, at least 44 skilled nursing facilities and 14 intermediate care facilities were "terminated." In one year, there were 28 "immediate and serious jeopardy" or "fast track" terminations.

Possibly the most significant change brought about by the IOM study has been a cooperative effort by consumer, professional and provider groups to reach consensus on comprehensive legislation needed to move forward the reforms recommended by IOM.

This effort sought to change the historical nature of discussions of nursing home legislative and regulatory reforms which had been characterized by confrontational postures and unproductive statemates. There was a conviction among the participants that the points of agreement were vastly more numerous than the points of disagreement and that the disagreements should not stand in the way of needed change.

Out of intensive and extensive discussions, an unprecedented consensus was forged on what constitutes the most constructive and realistic improvements in nursing home regulation at this time. The results of that year-long effort were released on April 24 in what we believe will be looked upon as a major turning point in national long term care policy. AHCA is proud to have been a part of that ambitious undertaking. This landmark package has the additional support of such groups as the National Citizens' Coalition for Nursing Home Reform, the American Association of Retired Persons, American Nurses' Association, and the National Council on the Aging.

If the litmus test of a "consensus" is reflected in concerns by some for "going too far, too fast" and by others for "not going far enough now," this package surely passes the test. But what the package does answer are two paramount questions, "What are the most critical and as yet unmet needs?" and "What is do-able now?" We believe the changes are not only do-able now, but would constitute the most significant nursing home legislation in 20 years.

Since the Institute of Medicine released its report, there have been a number of legislative proposals which have sought to implement its major recommendations. Some of these proposals are consistent with many of the "consensus papers." The two major nursing home quality bills are S.1108, introduced by Sen. George Mitchell (D-ME), and H.R.2270, introduced by Reps. John Dingell (D-MI) and Henry Waxman (D-CA).

Of the bills introduced to date, S.1108 most closely embodies the consensus positions. This legislation deals with issues paramount to quality care: the training of nurse aides; reviewing the ability of facilities to perform basic quality assurance activities; developing a national data system for resident assessment; and directing the development of quality care standards in such areas as nutrition and skin care.

I would like to discuss a few of the critical issues that arise in almost any discussion of the quality of long term care. First, I would like to comment on nurse aide training. AHCA believes that state governments should have the primary responsibility for developing programs for the training and competency testing of these important caregivers. At least 20 states have mandated nurse aide training. These programs vary from state-to-state because there are different needs within states which have led to different types of programs. At least 20 states have mandated nurse aide training. These programs vary from state-_to-state because there are different needs within states which have led to different types of programs.

There has also been controversy over what type of federal role is needed in directing state activities to sanction providers. We favor the approach taken in the "consensus papers" that states be required to have at their disposal an array of enforcement actions and that federal and state agencies should coordinate their enforcement actions. The "consensus papers" also recommend that HCFA give guidance and technical assistance to states. We strongly oppose the federal government directing states on how to sanction facilities. States know what type of authority they need for both licensing and certification purposes. We believe that federal mandates could tie the hands of state agencies and, in the long run, interfere with the basic goal -- achieving compliance or getting the provider out of the program.

The Health Care Financing Administration already has very powerful methods to police providers. Since the IOM study was released, HCFA has implemented new procedures for terminating Medicare and Medicaid providers that fail to meet program regulations and new federal intermediate sanctions which prohibit new admissions to problem facilities.

Perhaps the most costly and yet most important aspect of the proposed legislation deals with the nurse staffing in long term care facilities. We do not object in principle to requiring every Medicare- and Medicaid-certified nursing home in the country to have around-the-clock licensed nurses, either registered nurses (RNs) or licensed practical nurses (LPNs), so long as qualified nurses are available and the nursing home is guaranteed reimbursement for the additional staff.

However, we do not support a federal requirement of 24-hour registered nurse coverage in all facilities at this time for three reasons. First, we believe the price tag for such a requirement is prohibitively high. Second, we believe that licensed practical and vocational nurses do provide competent and caring nurse coverage, sufficient for the health and welfare of residents in many facilities. Third, nursing homes are facing a severe and growing problem of attracting and retaining registered nurses. The number of nursing students is decreasing rapidly with fewer young people choosing to enter the nursing profession. Long term care still labors under the image of a poor career choice for nurses. Turnover rates in some nursing homes across the country approach 100 percent. 'Round-the-clock registered nurse coverage is simply not a practical option in the forseeable future.

Revisions in the survey and certification process and other legislative proposals are long overdue. The inspection process, to be meaningful, must focus on resident care, and the people conducting the inspections must be knowledgeable about nursing home care and the needs of the elderly and chronically ill. From a provider's viewpoint, the worst thing that can happen during an inspection is to be confronted with someone who does not know the subject matter or the inspection process. We enthusiastically support legislative provisions that would provide for mandatory competency testing for surveyors. We also agree that the federal government should set constructive guidelines for states to use in carrying out their enforcement activities. While states need the flexibility to react to local needs, greater consistency within and between states is needed in such procedural areas as evaluating plans of correction, investigating complaints and forming special survey teams.

There are two additional changes providers believe are needed in the survey process. First, we believe that each state should be required to develop procedures for handling instances where there is professional disagreement between those giving and those inspecting nursing home care. Unless a facility is facing a serious sanction, it does not have any formal recourse for expressing disagreement with survey findings. These disagreements are occurring more frequently as surveys rightly focus more on patient care. They concern such subjects as the best way to give skin care, whether tube feedings are indicated, and even determining the most up-to-date methods of infection control.

In addition to procedures for handling professional disagreements, we believe that at times a complete new survey may be needed. On rare, but critical, occasions, facilities receive inspection reports that are totally out of line. We believe that facilities showing appropriate justification should be able to be reinspected by a second state or federal survey team. The findings of both surveys would then be used to determine the facility's compliance with requirements.

The American Health Care Association believes that the Commission on Long Term Care, which would be established by S.1108 would generate the kind of thoughtful and orderly study and recommendations needed to address the future quality issues of long term care. The Commission could advise Congress on such issues as appropriate staffing, the adequacy of Medicare and Medicaid reimbursement, and bed supply -- all critical components in our ability to provide access to needed long term care for all our nation's elderly.

Finally, federal legislation must recognize the critical relationship between quality of care and reimbursement. If Congress is, indeed, committed to improving quality of long term care, it must be equally committed to providing additional federal resources to cover the cost of additional care and services.

Laudable as these quality provisions are, let us not make the mistake of holding out false promises. If we wish to enhance care, we must recognize that there are costs involved in imposing additional requirements on nursing homes and increasing enforcement activities. Even changes in the survey process will result in increased costs. For example, facilities surveyed by HCFA's revised outcome-oriented survey process report that the deficiencies found when patient care is accurately evaluated can only be corrected with the addition of qualified staff. Without changing a single printed standard, survey teams throughout the country are ordering facilities to increase staff and increase the professional competency of their staff. Nursing homes are not immune from economic reality. Sources of reimbursement must be found to match the increased costs of any legislation enacted to improve nursing home quality.

In conclusion, I would like to urge the members of this Committee to look seriously at the comprehensive consumer-provider "consensus papers" that present in detail a workable legislative and regulatory proposal that would impact positively on the lives of 1.5 million current and future nursing home residents. This unprecedented consensus of 20 associations has produced what I feel are the most constructive and realistic recommendations on nursing home regulation in more than a decade.

With enactment of the consensus package, Congressional achievements would include the following:

- Rewrite and upgrade nursing home standards toward direct patient care, the protection of patients' rights and the quality of nursing home patient life;
- Develop a standardized system of patient needs assessment which can be used for care planning, quality assurance and payment purposes;
- Require minimum training of nurse aides and assure that nurse aides only carry out duties for which they have proven competence;
- Strengthen the survey and certification enforcement by requiring the element of surprise into inspections, making the nursing home ombudsman part of the enforcement process and increase the federal role;
- Improve the quality of nursing home surveyors by mandating minimum qualifications, training, and survey team composition; and
- Require state Medicaid agencies to have a program enforcement actions for deficient providers, without federal entanglement in how compliance is achieved.

AHCA was an active partner in developing the consumer-provider "consensus" on implementing the IOM recommendations and is a strong supporter of what we believe offers the most constructive and realistic improvements in nursing home regulation in 20 years.

I want to extend to the Committee the assistance of the American Health Care Association in working to implement these important recommendations to improve the quality of long term care.

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Mr. Levin. Thank you very, very much.

Now, Mr. Rodgers.

STATEMENT OF MICHAEL F. RODGERS, DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Rodgers. Thank you, Mr. Chairman.

I am here today on behalf of the American Association of Homes for the Aging. We would like to thank the subcommittee for allowing us to testify on an issue of critical importance.

The American Association of Homes for the Aging represents 3,200 providers of health, housing and community services. Our membership is entirely nonprofit, and about 75 percent are religious affiliated.

I would like to commend the subcommittee for holding these hearings today. It certainly signifies a genuine commitment on the part of Congress towards implementing meaningful reform in relationship to nursing home quality. AAHA supports the improvements set forth by the Institute of Medicine's study group on quality reforms in nursing homes.

Several legislative proposals are currently before Congress and address many of the recommendations included in the consensus agreement. AAHA recognizes that the implementation of the consensus agreement may represent significant costs in many areas. We are also cognizant that budgetary constraints may require a phased-in approach to many of the quality reform proposals.

Additionally, we recognize that Medicare represents a small portion of long term care costs. Nonetheless, as we move towards coordination and integration, quality reform will most certainly be a major concern to this subcommittee. It is important that we attempt to implement many of the recommendations that have been proposed.

In this regard, I would like to highlight AAHA's position on some of the recommendations that emanated out of the Institute of Medicine's study group over the past year.

In the area of assessment, the American Association of Homes for the Aging supports resident assessment as a basis for uniform and consistent structuring of individual case plans. A standard assessment process provides the factual basis for nursing home management, and can give regulatory agencies valuable information to determine level of care, staffing needs, and ultimately, case mix information necessary to reform the reimbursement process. The American Association of Homes for the Aging recommends that resident assessment be coordinated with existing evaluation efforts as well as coordinated with existing preadmission screening processes that are currently being utilized in many States.

In the area of nurse aide training, AAHA believes that this is one of the more critical areas necessary for ensuring quality of care. Provisions in Mr. Waxman's bill, H.R. 2270, seem to be thorough and practical in this regard. They would allow facilities to continue to design individual programs if such programs met both State and Federal criteria. States would be permitted to stipulate the number of hours, which is, in our estimation, a rational approach in dealing with the unique needs of the individual States. In combination with existing Federal requirements of in-service training, we believe that this should be sufficient to ensure quality. AAHA strongly recommends that such training continue to be an allowable cost under both Medicare and Medicaid programs.

In the area of residents' rights, AAHA supports the provision of establishing residents' rights as a condition of participation in both the Medicare and Medicaid programs. This is certainly a provision that can be implemented relatively inexpensively. A strong and meaningful residents rights statement provides the fundamental basis for not only quality of care but also quality of life for our elderly today. We are supportive of most of the provisions in the existing Senate and House legislation in the area of residents rights. We do, however, have some reservations that we have noted in our formal testimony, including issues related to individual resolution of grievances under transfer agreements, external review of patients who are currently under a regimen of psychotropic drugs, and some of the bed-hold provisions that have been proposed.

In the area of survey and certification, we are supportive of many of the provisions noted in House and Senate bills to address the survey and certification process. We are particularly in favor of trigger mechanisms that focus on facilities who consistently demonstrate poor performance. Under the legislation such facilities would be designated for an extended survey process. Obviously, this provision would reward good facilities by not subjecting them to an overly extended and bureaucratic survey. We think that this is an economical way to ultimately improve quality. We have also noted additional recommendations, Mr. Chairman, in this regard in our formal testimony.

In the area of enforcement, we strongly believe the facilities that present an immediate jeopardy to the health and safety of residents should not be permitted to participate in the Medicare/Medicaid program. We support, however, a range of intermediate sanctions for minor problems or if significant improvements are being made in facilities that have had problems in the past. AAHA thinks that this can best be achieved at the State level with increased Federal oversight of State efforts. The Federal role, clearly, should be one of monitoring and providing guidance, rather than direct intervention. In addition, there is also the need to improve communications between the State and Federal agencies in this process.

In the area of reimbursement, clearly, AAHA believes that reimbursement alone does not ensure quality, but it is certainly naive to think, or to expect, that quality reform can be achieved without some type of just-payment provisions. Medicare rates must reflect quality improvements, and this subcommittee, we hope, will recognize this fact as it begins to develop its own legislation.

Finally, Mr. Chairman, on a related point, but somewhat a small deviation from the quality area, we support provisions in your bill, H.R. 2470, that would remove the 3-day prior hospitalization as a necessary component for SNF or home health benefits.

I would again like to thank the committee for allowing us to testify today. We stand ready to assist the committee as it moves in the direction of improving the quality of care in nursing homes.

[The statement of Mr. Rodgers follows:]

Statement by

Michael F. Rodgers, Deputy Executive Vice President

Policy and Program Implementation

American Association of Homes for the Aging

Mr. Chairman and members of the Subcommittee, I am Michael F. Rodgers, Deputy Executive Vice President, Policy and Program Implementation, of the American Association of Homes for the Aging (AAHA).

AAHA is a national nonprofit association representing over 3200 nonprofit facilities providing health care, housing, and community services to more than 500,000 elderly individuals daily. Seventy-five percent of AAHA homes are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. With strong community involvement and longstanding community ties, AAHA members are committed to meeting the physical, social, psychological, emotional, and spiritual needs of their residents in a manner in which enhances residents' sense of self-worth and dignity and allows them to function at their highest level of independence.

On behalf of the Association, I would like to commend the Subcommittee for its continued diligence in seeking to effect positive change in the current nursing home regulatory system. We believe that the ongoing efforts of this Subcommittee, as evidenced by our presence here today, as well as the additional momentum provided by recent actions of the Senate Finance Committee and House Energy and Commerce Committee justify an optimism that this is the year we will see meaningful Medicare nursing home improvements effected. These improvements have been the topic of intense discussion by more than 20 provider, consumer, and health professional groups since the publication last year of the Institute of Medicine's report on "Improving the Quality of Care in Nursing Homes." The discussions of these groups, coordinated by the National Citizens' Coalition for Nursing Home Reform, have resulted in consensus positions addressing twelve key areas in which the IOM study made recommendations. The consensus documents, published as the "Campaign for Quality Care in Nursing Homes", present a series of workable improvements in the care of this nation's elderly. Significantly, the improvements set forth move away from concerns about facility structures and into affirmative actions for resident quality of life.

The Association is committed to supporting the reform measures set forth in the consensus documents and would encourage implementation of the entire consensus package as a goal for the Committee. We recognize, however, that the consensus package, taken as a whole, represents a significant cost item and that budget constraints may mandate a phased approach to nursing home reform. In this context I would like to outline some of the Association's suggestions, founded in the Campaign for Quality consensus, for immediate reform measures. I base these suggestions on measures we feel will make the greatest impact on nursing home quality for the largest number of elderly residents. I would also like to address concerns AAHA has regarding some legislative provisions already introduced in S. 1108, "The Medicare and Medicaid Nursing Home Quality Care Amendments of 1987," and H.R. 2270, "The Medicaid Nursing Home Quality Care Amendments of 1987," and offer recommendations which we believe will improve these provisions.

Resident Assessment

AAHA supports the concept of resident assessment as basic to the establishment and structuring of individual care plans. Additionally, periodic review provides not only a comparative basis for determining continued appropriateness of a care plan, but also offers a historical perspective to the identification of problematic, or potentially problematic, issues, and thereby aides in the development of therapeutic responses or interventions. Resident assessment is also valuable to nursing home management and regulatory agencies as a tool for determining staffing needs and for providing case mix information for survey and sampling purposes, and ultimately, we hope, reimbursement.

Inherent in AAHA's support for resident assessment is our concern that any system developed on a national level be workable. For this reason we advocate that this Subcommittee follow the provisions of both the Campaign for Quality Consensus and S. 1108 in requiring that the Secretary generate a minimum data set of core elements, common definitions, and guidelines for utilization, which would then be used by the States to develop assessment systems. Several states have already developed comprehensive resident assessment instruments which are linked to their reimbursement and survey and certification programs. These individual state assessment systems could continue, assuming that they met the Secretary's criteria, while the elements common to all systems would provide a uniform data set for comparison purposes at the federal level. The development of core elements and common definitions, rather than a comprehensive standardized assessment tool, would serve to avoid many of the problems experienced in the 1970's, when the federal government developed the Patient Appraisal and Care Evaluation (PACE), a 40 page assessment form which became too unwieldy for procedural use and eventually died of its own weight. AAHA suggests that the Secretary be encouraged to review the many excellent state and facility-specific systems which currently exist before establishing these core elements, definitions, and guidelines. AAHA further recommends that federal assessment requirements be coordinated with State preadmission screening processes, to the extent possible, to avoid the unnecessary and costly duplication of tests used for diagnostic purposes.

The Association supports the training of all pertinent personnel in the use of the assessment instrument as essential to ensuring the greatest possible degree of both accuracy and consistency. To effect that training, AAHA recognizes the need for phased-in implementation of resident assessment, and is in agreement that all resident assessments should be coordinated by a registered nurse. Senate Bill 1108 addresses these points effectively.

Another strong concern of AAHA's with regard to resident assessment lies with the provision in H.R. 2270 which calls for penalties for falsification. While the Association recognizes the intent of this provision and agrees that falsification of resident assessments must not be condoned, we believe that the inherent threat of such is a provision is itself a quality disincentive. We fear that even the suggestion of this type of sanction will discourage qualified health professionals, particularly registered nurses, from seeking employment in a nursing home. Our members already face recruitment problems brought about by the universally acknowledged shortage of nurses and by our economic disadvantage when competing for available personnel. The possibility of sanctions for inaccurate assessments can only exacerbate these recruitment difficulties. AAHA urges that the penalty provision of H.R. 2270 be deleted in favor of an alternate method such as that used by the New York State Medicaid Agency in its RUGs (Resource Utilization Groups) system. Under this system, if the state agency identifies a pattern of inaccurate assessments, the facility is compelled to hire an independent assessment auditor, at the facility's expense, to perform all assessments for a given period of time. AAHA believes that such a system on a national level would ensure an efficient and accurate resident assessment process.

Nurse Aide Training

AAHA recognizes the magnitude of resident care which is provided by nurse aides and believes the issue of nurse aide training is one of critical importance. We strongly encourage the Subcommittee to include nurse aide training in any nursing home quality reform legislation passed by the 100th Congress.

The Association considers the great majority of requirements for nurse aide training outlined in H.R. 2270 to be thorough and practical. We are highly supportive of the provision which permits facilities with established programs to continue their training efforts as long as the programs meet Federal criteria and are approved by the State. Facilities which currently do not have programs established will have the benefit of state-approved programs to develop this training. We also concur with the provision in H.R. 2270 which leaves the number of hours of required training to the discretion of the states, as opposed to the 100-hour minimum training requirement proposed by S. 1108. We believe 100-hour figure, in combination with the existing mandate for facilities to provide an ongoing educational program of inservice training (CFR:405.1121(h), Staff Development), exceeds the amount of time required to provide a quality-oriented training program of classroom and clinical instruction. Based on extensive discussions with members whose facilities have long-standing programs, AAHA would support a requirement for 80-hour programs if a national standard for nurse aide training were to be established.

Resident Rights

Throughout its 26 year history, the American Association of Homes for the Aging has championed resident rights. AAHA has long supported the elevation of residents' rights to a condition of participation, a position which fits squarely into the Association's basic philosophy that aging is a natural process which should not limit or change a person's right to autonomy and to experience life to its fullest. The commitment of AAHA members to care for the total person includes providing care in a manner which enhances the resident's sense of self-worth and dignity, and recognizes that residents' rights extend beyond the basic protection of civil liberties and legal rights to include the concepts of quality of care and quality of life.

In 1975, prior to the enactment of federal standards, AAHA's membership adopted a resident "Bill of Rights." The Association has also made available to nursing home administrators and the general public such publications as Social Components of Care, identifying those physical or program arrangements which allow and encourage residents to realize themselves fully as individuals with personal dignity and as members of the community, and Resident Decision Making in Homes for the Aging, a step-by-stp guide to starting a resident council or improving an existing one. Most recently, AAHA, with the support of Peat, Marwick, Mitchell & Co., has published a series of consumer brochures to help elderly individuals better understand the variety of housing, services, and care options provided by AAHA members.

AAHA considers the resident rights addressed by both S. 1108 and H.R. 2270 to be important to maintaining not only the individuals' self-worth, but also their sense of control over their environment, to the maximum extent permitted within a communal setting. Our only caution with the provision as contained in S. 1108 concerns the section requiring prompt resolution of grievances an individual may have with respect to the behavior of other residents. In an extreme case such resolutions might require intrafacility transfer of one of the residents; a possibility not acknowledged in this legislation. We suggest that this and any similiar legislative initiative include a transfer and discharge provision to recognize the possibility that legitimate transfer might result from the prompt resolution of a resident's grievance.

The Association has two concerns with the resident rights section of H.R. 2270. The first is the provision which calls for annual, independent, external review of any resident receiving psychotropic drugs. We believe that the legislation fails to clarify the qualifications of this person, and how his or her observations are to be reconciled with those of the facilities' own consulting pharmacists, the attending physician, and the surveyors. We are also curious about the manner in which this individual is to be compensated for services which appear to be highly duplicative.

Our second reservation involves resident transfer rights, specifically the provision which requires facilities to establish procedures for residents whose medical leave has exceeded the time period allowed under the bed-hold provisions of the State plan. AAHA's concern is that a requirement of this nature has the potential to result in practice as a "swinging door" policy, thus creating a climate of uncertainty, disruption, and instability for the resident in question, for the residents remaining in the facility, and for the provider. Questions which must be raised include the type of discharge planning that will have to occur from an acute care perspective. If the original facility cannot readmit the resident, the hospital discharge planners are faced with developing a plan which may eventually encompass several transfers before the resident can return to his/her original facility. In addition to the problems faced with discharge planning, long term care facilities face the difficulties in care planning associated with holding residents awaiting space in their original home. The effects on the resident of possible multiple transfers, and the ramifications for potential first admissions are factors which must also be addressed. The provision does not indicate whether "return admissions" would take precedence, but one implicit consequence would be a reduction in availability of space for first-time admissions.

Survey and Certification

AAHA is supportive of provisions in H.R. 2270 and S. 1108 designed to improve the survey and certification process for nursing homes. The Association particularly favors the concept of a trigger mechanism for focusing on facilities which demonstrate poor performance with regard to specified requirements. AAHA believes the development of a protocol for a standard and extended survey process may prove to be more cost effective by more efficiently targeting resources on substandard facilities. At the same time, this approach would also serve as deserved means of recognition for homes which consistently provide quality care.

AAHA also backs the provision in S. 1108 which calls for a staggered survey schedule, with a range of 9-15 months, as one of the best means of assuring that surveys will be unannounced. Additionally, the Association strongly concurs with the bill's requirement that survey teams be multidisciplinary and that surveyors receive training and competency testing, with annual training updates.

Our over-all support for the provisions dealing with survey and certification improvements however, is tempered by four concerns. First, H.R. 2270 would prohibit states from using as a surveyor any individual who has served as a nursing home consultant within the past two years. AAHA recognizes the apparent conflict of interest in using a surveyor who is currently also serving as consultant to one or more facilities to help the facilities achieve compliance for nursing home certification. However, the Association believes that the prohibition contained in H.R. 2270 is overly restrictive and may prove disadvantageous. Such a two-year ban on hiring would deny states the opportunity for recruiting individuals for surveyor positions who have an indepth understanding of the functioning of a nursing home, as well as the regulatory system. The Association recommends that the legislation proposed by the Subcommittee prohibit a former consultant from being sent to a specific facility for which the individual has provided consultation services, without further restrictions.

Second, AAHA objects to the provision in H.R. 2270 which would reduce federal payments to States with inadequate state survey performance. We believe there is general agreement that state budgets are strained and that many states are already uneasy about the adequacy of their survey budgets. A reduction in payment for poor performance can only serve to intensify the performance problems, and can result in scheduling difficulties as well. If survey and certification budgets are penalized, some facilities could remain unsurveyed, endangering their participation in the Medicare and Medicaid programs. This is ultimately a consumer issue; facilities which are not Medicare and/or Medicaid certified cannot provide access to Medicare and/or Medicaid residents.

In this same vein, the importance of having timely and well-conducted surveys is the reason AAHA, along with the other participants of the Campaign for Nursing Home Quality, is advocating 100% federal funding for the costs of nursing home survey and certification for five years. The Federal role in protecting nursing home residents and assuring quality care cannot be minimized. The growing need for a tangible commitment to this role has recently been evidenced in the increased burden placed on states through implementation of the new Long Term Care Survey Process (PaCS). The Association views PaCS, with its shift in focus from paperwork compliance to patient care, as a crucial step toward achieving consistent, reliable assessment of quality care. Sufficient funding for nursing home survey and certification activities is inextricably tied to ensuring this opportunity for success. We urge the Committee to adopt a stance which reflects the Campaign for Quality consensus.

Finally, AAHA has one remaining concern with the provision of H.R. 2270 requiring notice to the attending physician and the Nursing Facility Administrator Licensing Board when poor quality care is identified within a nursing home. While we agree in concept with this provision, we believe the term "poor quality" is subjective and needs further elaboration. The provision does not qualify the criteria for notification in terms of severity or frequency of noncompliance. If this Subcommittee considers a similar provision, we recommend that the language be modified to require notification to these entities in instances of noncompliance severe enough to warrant sanction activity.

Enforcement

AAHA concurs that facilities demonstrating conditions which have been determined to "immediately jeopardize the health and safety of its residents" should not be permitted to continue participating in the Medicaid program until such conditions are rectified. The Association is also supportive of the use of intermediate sanctions as an alternative to termination as the sole recourse in responding to substandard conditions where "immediate jeopardy" does not exist. This is an area, however, where we would encourage the Subcommittee to evaluate carefully the array of federal and state intermediate sanctions that currently exist in order to determine what federal refinements or additions, if any, may be needed. Additionally, existing State authority and the interplay between state and federal sanctions must be addressed and clarified so that application of sanctions does not effectively render a facility unable to continue providing care.

AAHA continues to believe that the issue of intermediate sanctions would best be addressed at the state level. However, we do appreciate the argument that a layer of federal sanctions is needed because some states are reportedly reluctant to impose sanctions for several reasons. We concur that increased oversight is needed to ensure that states use their enforcement authority effectively, but contend that the Federal role should be primarily one of monitoring and guidance as opposed to direct intervention. AAHA supports the Campaign for Quality Consensus position on enforcement which includes a mandate for states to develop a range of enforcement actions reponsive to the severity and frequency of deficiencies; authorizes a federal ban on payment for admissions in conjunction with look-behind activities; and which increases look-behind activities to a minimum of 5 per state or 5% per state, whichever is larger, to be conducted within one month of the state survey. The Association also concurs that some type of administrative sanction, possibly in the form of contempt citations, or fines assessed against a general fund, should be established on the federal level for imposition against states who have failed to adequately perform survey and certification functions.

The above arguments notwithstanding, the Association's primary concern with the implementation of both federal and state alternative sanctions has traditionally centered on the existing lack of a mechanism assuring communication between federal and state agencies.

The stated intent of the existing federal intermediate sanction is to "promote correction of deficiencies rather than to simply exclude facilities from the program" (see: Fed. Reg. Vol. 50. No. 35/2/21/85 - Proposed rule), thereby avoiding or forestalling negative consequences for residents such as those resulting from transfer trauma. It must be assumed that state sanctions are utilized with a similiar intent. However, while HCFA has stated that "state sanctions may not supersede or otherwise conflict with Federal sanctions" (see: Fed. Reg. Vol. 51, No. 128/7/3/86), there is no current law or regulation which requires states to obtain consent or otherwise notify HCFA of the implementation of state sanctions. AAHA has remained very concerned that State and Federal intermediate sanctions may, and will possibly continue to be permitted to run concurrently, thereby, placing the facilities in a position of "double jeopardy", and creating the potential for effective termination in the name of an intermediate response.

AAHA recognizes the intent of both S. 1108 and H.R. 2270 to remedy this situation. H.R. 2270's "Special Rules" provision provides guidelines for the imposition of sanctions when the State and Secretary do not agree on a finding of noncompliance. S. 1108 requires the Secretary to review sanctions imposed by the State(s) every 3 months to determine their effectiveness, a provision we believe provides half of the solution. Although the State/Federal relationship is implied, there is still no concrete provision for notification by state agencies when any agency has imposed an alternate sanction. At a minimum, any legislation in this area must clarify that such notice is necessary. It cannot be assumed that this will occur of its own accord.

Finally, AAHA would like to reiterate its position on the implementation of penalties, on a state or federal level, which are contradictory to the function of intermediate or alternate sanctions.

The Association believes that a proposal such as that contained in H.R. 2270, to assign Secretarial authority to impose a civil money penalty not to exceed $10,000 for each day of noncompliance, is excessive as an intermediate sanction. The impact of imposing a civil penalty in such a large amount, even apart from possibly compounding the burden by using other existing sanctions, will likely result in a swift, if not immediate, crippling of a facility's capability to continue operations.

REIMBURSEMENT

There is general agreement, we believe, that adequate reimbursement alone does not assure quality of care in nursing homes. It would be naive to expect, however, that nursing home quality can be achieved without just payment for services.

We understand that the jurisdiction of the Committee on Ways and Means extends only to Medicare, representing a relatively small number of nursing home residents. However, we ask the Subcommittee to ensure that Medicare rates reflect any quality improvements which emanate from the proposed legislation. We also ask the Subcommittee members for assistance during the budget reconciliation process in removing the Medicare upper limitation from Medicare payments.

CONCLUSION

The American Association of Homes for the Aging appreciates the opportunity to appear before the Subcommittee today. We look forward to working with the Subcommittee and full Committee as nursing home reform legislation proceeds through the session.

Mr. LEVIN. Thank you for your comments and for your very complete statement which, as mentioned, will be in the record.

Before the chairman and the ranking member take over, let me just ask a few questions to lay the foundations, at least, so I understand them. In terms of your two associations, yours, the AAHA represents mostly nonprofit?

Mr. RODGERS. That is correct. All nonprofits.

Mr. LEVIN. And the American Health Care Association would represent both profit and nonprofit?

Mr. WILLGING. The American Health Care Association represents both. We have 9,000 members, 1,200 of whom are nonprofit.

Mr. LEVIN. So there is some overlap?

Mr. WILLGING. There is some. AAHA is much more heavily involved in what are referred to as residential care facilities than is the American Health Care Association. While we do have residential care members, we are predominantly a nursing home association.

Mr. LEVIN. Yours is primarily residential?

Mr. WILLGING. No.

Mr. LEVIN. Yours is, and yours is nursing home?

Mr. WILLGING. Primarily nursing homes.

Mr. LEVIN. Okay. Now, the difference is what?

Mr. RODGERS. If you would take a look at the 3,200 members in our association, they break out fairly evenly. One-third are nursing home, one-third represent assisted housing programs for the elderly, and another third are facilities we call continuing care retirement communities. These include both residential housing as well as the component that relates to skilled nursing care.

Mr. LEVIN. Let me ask you then to try to get out the differences that exist here. If you would, describe the main differences that your two associations have as you approach the issues discussed today, the IOM report, et cetera.

What are your different perspectives?

Mr. WILLGING. At the risk of being disappointingly noncontroversial, Mr. Chairman, I do not think we have major differences because both the American Association of Homes for the Aging and the American Health Care Association were parties to this consensus activity which has been developing over the course of the last year, and both of us, AAHA and the American Health Care Association, were among the original group that developed these 12 consensus papers.

We may differ in terms of some of the nuances, but in terms of the basic thrust of the Institute of Medicine study and the legislative proposals we would like to see enacted, I would have to say, and I will not speak for Mr. Rodgers, that we are in essential agreement, with 55 separate groups of one kind or another in Washington, D.C., from the professional groups, unions, providers, consumers, everyone but the Congress, up to this point. But we are working on that.

Mr. LEVIN. All right. If you would, Mr. Rodgers, do you agree with that characterization?

Mr. RODGERS. I would essentially agree with this characterization. I think that in the past this has not always been the case. There have been some differences in the approach to problems, but

I think that recognizing that the Institute of Medicine's recommendations would require the building of consensus, it is relatively historic that you have the industry, consumers, as well as the various trade associations sitting down and coming to agreement.

There are, obviously, a variety of supplemental viewpoints that have expressed some differences between the various groups, but by and large on those 12 major areas, going from resident rights through enforcement through nurse aide training, staffing, et cetera, there has been wide consensus.

Mr. **Levin**. And that would hold, basically, as to the Federal role in this whole field.

All right. Then let me ask, if I might, Toby Edelman, do you agree with that characterization as to the meaning of the consensus? If you had to name a difference of significance between your position and those of the two associations here, what is it?

I do not want to create a difference where there is none, but just help us.

Ms. **Edelman**. I should say that we are probably as surprised as you are that there was as much consensus. I think when we started this process people thought that it would not get that far, but as we talked and met day after day in very intensive discussions, there were many points of agreement. The kinds of disagreement you will see are whether nurse aide training should be 80 hours, or 100 hours, or left to States. I mean, that kind of detail.

But the general concept of having aides be trained and not perform any duties until they are competent to perform them, everybody agreed on.

Mr. **Levin**. And as to the Federal role, there is some, but not major disagreement as to training or other issues? I mean, there is a basic common ground?

Ms. **Edelman**. I think there is a very basic common ground on these areas.

Mr. **Levin**. Then, I will finish by asking one of the chairman's many perceptive questions. We will not be able to do everything. From your perspectives, what would we best do first? The four of you, if you had to prioritize for the Congress, what should we do in this session?

Mr. **Willging**. I will speak, I guess, only for myself, but if one had to choose only one thing——

Mr. **Levin**. Well, you can choose several, but from many, many.

Mr. **Willging**. I guess I would start by continuing the process begun—but perhaps inadequately begun—by the Health Care Finance Administration which focused on the IOM study; that we reorient our attention in terms of providers, as well as our attention as surveyors, and certification directors, toward the care provided the patient; toward the assessment process of the patient's needs and that the resources be based on that type of a process; that we move away from bricks and mortar, from paperwork, from the bureaucratic types of "administrivia" that we have traditionally looked to in terms of reviewing whether a nursing home is doing a good job or a bad job, focus on the patient and away from the process.

I think it is also important to recognize this difficult to define, very ephemeral but equally critical issue referred to as the quality of life. We have focused over the years, and perhaps rightly so, given the problems of the past that this industry had, on the nuts and bolts, hands-on care provided patients.

We should not move away from that, but we should at least add to that critical priority the ambience, the dignity, the privacy, the rights of the patient in terms of quality of life. Those, I suspect, would be my first two criteria in terms of movement.

I think we also—and I am expected to say this, because it is true—we have got to recognize, which we have not in this country, that we must be willing not just to ask for enhanced standards of care, we must as a society be willing to pay for it. If we are unwilling to do that, we have simply decreased the quality we can provide, and I submit, provided false promises to the American public.

Mr. LEVIN. Do you want to start, and then we will finish going down the line.

Mr. RODGERS. I am not sure that we really have taken a look at the 12 issues and listed them in a hierarchical structure. We believe that there are a number of issues that clearly could be implemented at little cost. As I noted in the testimony in the area of residents' rights, some of the issues covered there could be implemented as a condition of participation without major costs to facilities or to the Government.

Additionally, we think that survey and certification improvements are important provisions, and issues related to enforcement are also important areas.

I would underscore what Mr. Willging said relative to reimbursement. Clearly, we do not want to come in here and say that this is our first priority, but as we begin to examine quality and implementing some of the recommendations that came out of the Institute of Medicine's report, this is an important concern.

Mr. LEVIN. Mr. Bryant?

Mr. BRYANT. I would basically agree with the two gentlemen before me in looking at the quality of life, the improvements that are necessary in that. As representing those that are on a daily basis involved in nursing homes——

I think Mr. Rodgers, maybe mentioned this—is the enforcement aspect.

Basically, in your federal system that you now have you are either in the program or you are out of the program. There is not in-between. The States need to have some systems that are in place, whether we do an extended survey, a periodic survey, a survey at 9 months, 15 months, whenever we do a survey, what do you do to those providers that will not, for whatever reason, come into compliance.

It is not necessarily a simple thing that we ought to just throw the rascals completely out of the program henceforth and forever more, but there are a whole range of intermediate sanctions. There are some mentioned in H.R. 2270. There may be some others that States have.

I really think that when you revise the standards, the conditions for participation, then you have to have a mechanism to enforce that.

Mr. LEVIN. And the Federal legislation should encompass that?

Mr. **Bryant**. The Federal should encompass it, or at least give the States permission or direction toward the Secretary to develop those as a part of their program. I realize today we are speaking primarily of Medicare, which is a national program run by HCFA, but there is a far greater business involved with Medicaid that is a State administered program. So you have got to make allowances for that in your legislation.

Mr. **Levin**. Ms. Edelman.

Ms. **Edelman**. I agree with Mr. Rodgers that many of the proposals that we have come to a consensus do not cost money. Varying the survey cycles between 9 and 15 months instead of every 12th month on the same date does not really cost a different amount, but it could make a big change. Asking State and Federal Governments to coordinate their efforts and work together is not necessarily a very costly item at all. It just makes some sense.

In terms of the issues we have selected that do cost money, I think the two that we would probably put emphasis on and call for legislation this year above all others are resident assessment, so that residents really are looked at comprehensively by a team and that what is determined is the basis for the care for that resident and the evaluation of the facility. That seems critical.

The other critical area is aide training. About 90 to 95 percent of the care in this country is provided by nurse aides, and in too many States there are no requirements for training. People walk in off the street and provide care.

We have got to change that. We have got to have people who are competent to provide care to the very dependent and ill people who are living in nursing homes.

So those are the two cost items, I think, that are the biggest priorities for us.

Mr. **Levin**. You two work so well together you can choose who goes next.

Mr. **Gradison**. I have no questions, Mr. Chairman.

Chairman **Stark**. I just have one question. I think it is probably in response to Mr. Bryant's concern, and I do not know what we can do about it. I hear periodically that some nursing homes will be under continuous investigation by the State of California.

They generally will be right on the verge of being closed up. Then these clowns who run it will go out and get all the residents all ginned up and the relatives of the residents, and I gather these people are fragile enough so they can be convinced that they are going to be thrown out on the street with no place to sleep or food to eat. So the relatives show up at my town meetings.

They lynch me because the State is probably going to just close the nursing home on them, when in my opinion they probably ought to put the operators in jail for doing what I would call senior abusing.

Is not the biggest problem defining what is humane care? It just seems to me that we have had from time to time in California what I think of as criminal mistreatment. The penultimate one was Jones. He took a lot of people out of my district over to Guyana. And that is the kind of mistreatment we could explore here all day, but it is not unusual for people with resident facilities, or the little Mom and Pops—we have a whole bunch of them—where people get 6, 8, 10 boarders, as I would call them, but they are, I suppose, nursing homes. I just think the possibilities for abuse are widespread.

Can we deal with that in law, or am I just missing something? I guess we make a big step towards the bigger institutions, but I am not sure that is where all the problems are. What do you do in Texas?

Mr. BRYANT. I am in Texas, and we do have several pieces of legislation in Texas dealing with abuse and neglect, and if a person is elderly and in a nursing home and they are abused and neglected, that is a third degree felony and it is a penitentiary offense. And there have been some people that have been convicted under that, working with the district attorneys. And the attorney general's office has taken a very active role in that.

Then, in the Medicaid agency, they have, in addition to child protective laws, there are elderly protective laws for dealing with those individuals that are in the community, or in this small facility that you say, we begin licensure at four beds. If it is less than four beds, it is exempt from State law and it is not required to be licensed, and you have situations involved in that. We call them unlicensed facilities.

Chairman STARK. But they are still subject to this felony——

Mr. BRYANT. Yes, sir. They are still subject to the adult protective situation. There was one situation where we were involved with the court and the attorney general's office, and basically close one such facility one day, and several of those that we have been involved in. There, again, it is very much like your child protective laws. This one deals with adult protection, even up to and perhaps the State taking custody of the person in question to protect them from physical abuse, financial abuse, exploitation. You name it, it is there.

Chairman STARK. Does California or New York have a law like that? Does anybody know?

Mr. WILLGING. I am not sure if California has a law specifically like that.

Chairman STARK. Does New York?

Ms. EDELMAN. I believe it does, but I am not sure.

Chairman STARK. Should there be a Federal law? I hope we would not preempt the States. Should it be a Federal felony as far as this kind of thing is concerned? Or a provision that if a State does not have it, a Federal statute takes effect? Does anybody have any feeling about that? I like the idea.

Mr. WILLGING. Certainly, I think I could support the fact that if anyone—provider of health services, nursing home or any other type of service—is engaging in felonious activity there should be a law that provides retribution.

I do want to suggest, however, and I want to make this unequivocally clear, is that with 16,000 licensed nursing homes in this country, it is unfortunate, but it is at the same time true, that you will on occasion have activities perpetrated which are totally unacceptable under anyone's code of ethics, under anyone's set of standards.

The industry I represent wants also to make it unequivocally clear that in those cases not only should such a provider be dismissed from the Medicare/Medicaid program, that provider should not be providing services to any patient, any resident, under any guise whatsoever. Indeed, my suggestion to the Health Care Financing Administration is that they put in tough new rules case fast track terminations. That is, if a provider is found to be engaging in practices that pose a jeopardy to the patient, there are 5 to 23 day processes in place.

I have suggested 5 to 23 days is probably too long, if indeed, immediate jeopardy is being posed to the patient. I think that there is no question, and I suspect my colleagues will support me, that we cannot tolerate it. This industry has suffered too long from the public perceptions that have come about by a small minority of facilities. But in this industry where you are dealing with the most vulnerable populations imaginable, one is too many.

We cannot tolerate them. It does us no good as an industry. It does the consumers no good, and it does the Government no good.

Ms. **Edelman**. Mr. Stark, may I say something?

Chairman **Stark**. Sure, go ahead.

Ms. **Edelman**. You are describing a situation where a facility is repeatedly out of compliance and nothing can be done, or it gets to the point of closing. I think one problem is that in the past the only possibility has been termination. It is either all or nothing.

What we have all agreed to is that we need some intermediate ways to deal with facilities before it gets to the point where it is so terrible that people's lives are in danger. We have to take some intermediate steps and not let it get to that point.

Chairman **Stark**. I think also the idea is that right now the worst thing that happens is that somebody loses their license, probably, in California. If you own the facilities, maybe that is serious. But in Texas you put it right up there with child abuse and spouse bashing and you can do some hard time.

A lot of people treat that differently than paying a fine. It is one thing to visit the State penitentiary in Texas and another thing just to visit your banker to raise enough money to pay a fine. I think that is unfortunate sometimes, but maybe that is the kind of threat that is needed.

Mr. **Bryant**. The abuse and neglect provision is basically directed not necessarily at the person, the owner of the facility, but those people that perpetrated the situation. And you also mentioned this thing in the community. There are those in the community that are taking care of one or two people that are not subject to the laws, they are not members of these organizations, they are not subject to licensure.

But they are subject to this adult protection situation that is involved. There is, perhaps, a bigger segment out there than we realize of that kind of people.

Ms. **Edelman**. There are prosecutions now that go on, but primarily by the Medicaid fraud control units. But what troubles me is that sometimes the problem is not intentional abuse. I mean, there are those problems, obviously, but another serious problem is that a lot of the aides do things that are wrong because they just do not know what to do.

There was testimony last year in front of Mr. Pepper by someone who was identified as a nurse aide X about how when she was working as a nurse aide—she is now a divinity student—she did not know how to turn a patient and she did not know what to do, and they kept turning somebody who was crying out in pain and screaming and finally the woman went to the hospital and it turned out she had cancer of the bones and every time they turned her and moved her they were literally breaking her bones.

Chairman **Stark**. I understand what you are saying. If you have people who are generally caring, sensitive people, and somebody says, "ouch", they are going to respond.

Ms. **Edelman**. Well, she did. But she still did not know what to do.

Chairman **Stark**. But ostensibly she knew where to go. She had a supervisor or something. It is the person who gets a kick out of this that I am worried about, that loves to bounce somebody like that around just because they get their jollies by hearing somebody scream in pain. That is the person that I am worried about, to get those out of the system.

Mr. **Willging**. Mr. Chairman, we do not want to minimize the need to deal with that, and to deal with that kind of an issue swiftly, but Ms. Edelman has, I think, raised what is to me, at least, perhaps the more complex, perhaps less immediately tractable problem, and that is that we are an industry where 90 percent of the care is provided by people who in most States are not paid more than minimum wage.

We are talking about people who in most States are for the most part illiterate. We are talking about people who, and we admit, have not been as well trained as they should be. And that is why we, the industry, have supported the nurse aide training provision within the consensus docments. But that is why we also have to bring to bear constantly the question of financing because the laws of economics have not been repealed for the nursing home industry, despite the fact that many would like it so.

You do, get what you pay for. I would contend in this industry that you probably get more than you pay for. We are having serious difficulties even finding people, because you can walk down the street to the McDonalds and see in every one in the country a sign posted in the window, "Help Wanted." And they are not paying minimum wage. They are paying $1, $2 more than minimum wage.

I do not, as is true of my colleague, Mr. Rodgers, want to make reimbursement the primary issue we are dealing with here. It is not. But it is a necessary condition and we have got to bring that discussion into these dialogues.

Mr. **Levin**. What percentage of the industry is organized into labor organizations?

Mr. **Willging**. This industry, although it varies from part of the country to part of the country, is not dramatically organized. I think it is a small percentage, around 20 percent.

Chairman **Stark**. Mostly in California.

Mr. **Levin**. Well, okay.

Mr. **Rodgers**. Mr. Chairman, I would like to comment on the point that you made earlier. As you begin to look at the survey and certification process and its relationship to quality care, we must raise the question "What is quality?" Is it a series of paperwork compliance? Is a facility getting into difficulty because of a lack of sophistication in relationship to non-patient-care issues? I think that as you begin to take a look at some of the smaller nursing homes, they offer very good quality care, but on paper, because of bureaucratic impediments, may have some deficiency.

If we examine standards of quality I think we get into some more subjective evaluations. Is the facility pleasant? Are there odors? Are there other problems that are apparent to one's eyes?

So I think that we need a rational approach in areas of intermediate sanctions. There are ways in which you can begin to improve quality through the use of such sanctions in cases where there is perhaps noncompliance in noncritical areas. I would also agree with my colleagues that where there is flagrant abuse, or where there is jeopardy to both the health, welfare and safety to the residents, those facilities should not be permitted to continue operation.

Mr. LEVIN. Well, thank you. It has been very informative. I guess where there is consensus outside of Government, it should put some pressure within Government, within the executive as well as the legislative branch.

Mr. WILLGING. An astute observation.

Mr. LEVIN. Yes. They rarely follow.

Thanks very much, and the chairman will take over for our next witness.

Chairman STARK. Our last witness will deal with the State health insurance, Commissioner Peter Gillies, insurance commissioner, Connecticut Department of Insurance.

Commissioner, without objection your complete statement will appear in the record, and if you would like to expand, elaborate or supplement it in any way you are comfortable, please proceed.

STATEMENT OF PETER W. GILLIES, INSURANCE COMMISSIONER, CONNECTICUT DEPARTMENT OF INSURANCE, ACCOMPANIED BY JOHN SANSONE, DIRECTOR, LIFE AND HEALTH DIVISION

Mr. GILLIES. Fine. Thank you very much.

Mr. Chairman and members of the Health Subcommittee, my name is Peter W. Gillies and I am the insurance commissioner for the State of Connecticut. I appreciate the opportunity to testify before the subcommittee today and to discuss briefly Connecticut's experience with insurance risk pools. Also with me here today is Mr. John Sansone, to my left, who is the director of the life and health division within the department of insurance. If there is no objection, as you have already indicated, then my statement will be made a part of the record.

Chairman STARK. Without objection.

Mr. GILLIES. The Connecticut Comprehensive Health Care plan was created by statute in 1975 and was the first insurance risk pool system created nationwide. Under our CHCP every insurance carrier offering individual health insurance in Connecticut shall, as a condition of transacting health insurance, make available to every resident of the State an individual comprehensive health care plan, except for those who are both 65 years of age or older and eligible for Medicare. Each enrollee shall have a choice of low option, middle option or high option deductible. The amounts of the respective deductibles may be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index. The current deductibles are $400, $1,000 and $1,500, double the original amounts that were set forth when the statute was created. The actual selection of the deductible is made by the individual insured. Individual plans may be made available through participation in the Health Reinsurance Association, or a residual market association. Premiums charged by other plans than those offered by the Health Reinsurance Association may not exceed the premiums charged by the association.

When the original legislation was adopted in 1975, it included a provision for the assessment of every self-insurer in our State. The purpose of the inclusion was to expand the financial base for underwriting any losses incurred in the operation of the plan. A Federal suit in the second circuit determined this requirement violated the ERISA provision. As a consequence, this provision is no longer an applicable part of the law. Coverage provided under the plan is specifically mandated by statute and cannot be denied.

No one can be refused, regardless of their medical condition at the time of application. The only limitation is that coverage will not be available for one year on preexisting conditions. Benefits are paid at the rate of 80 percent of covered expenses after application of the deductible portion selected by the insured.

After an individual has paid $2,000 if single, or $4,000 in a family contract in any year the plan will pay 100 percent of the covered expenses incurred in that year. There is a maximum lifetime benefit of $1 million.

The health plan is administered under the auspices of the nonprofit entity, the Health Reinsurance Association. At the present time, there are approximately 35,000 Connecticut residents insured under the comprehensive health care plan. It is particularly attractive for persons who suffer from mental illness which requires inpatient hospital treatment, because of the $1 million available.

Another area of coverage, and one that the insurers are most apprehensive about, is the treatment of AIDS. It is estimated that the annual cost of treatment for this illness is approximately $50,000 per patient. The numbers of individuals who may require treatment is unknown, but it may be substantial.

The result of the comprehensive health care plan is the very beneficial effect of providing health insurance to many thousands of individuals who would otherwise be unable to obtain it. Thus, the problem of availability has been addressed. However, the question of affordability remains an important ingredient.

Coverage for a husband and wife aged 50 to 54 with a dependent child would be subject to an annual premium of between $3,660 to $6,149, depending upon the deductible chosen. The plan in Connecticut—and I speaking about the health reinsurance plan itself—sustained an operating loss of $885,375 for 1986, which shall be assessed against the member insurers. Blue Cross sustained a $3.5 million loss during the same period.

To look at it another way, in the first instance, the loss comes out to about 28 cents for every resident in Connecticut, as opposed to the Blue Cross of about $1.15 per resident.

Connecticut, unlike some programs in other States, does not provide for a premium tax offset, although a request for such legislation was proposed at the last session of the general assembly, but it did not get out of committee.

Another unique characteristic of the Connecticut plan is its absolute enrollment provision. There is no requirement that an individual be denied coverage in other programs before being eligible. It is my understanding that negotiations are currently being carried on by the insurance industry and employer self-insurers with an aim toward removing the ERISA exemptions and permitting self-insurance participation in the State of Connecticut. This expansion of the base, in my opinion, makes good sense and I would encourage continued discussions along those lines.

Once again I would like to thank you, Mr. Chairman, for letting us speak this morning. If there are any questions, and I am sure there will be, with your permission, if I deem it in the expertise of Mr. John Sansone as opposed to myself, I will simply refer a response to him.

STATEMENT OF PETER W. GILLIES, COMMISSIONER, CONNECTICUT DEPARTMENT OF INSURANCE

Mr. Chairman and Members of the Health Subcommittee, my name is Peter W. Gillies, and I am the Insurance Commissioner for the State of Connecticut. I appreciate the opportunity to testify before the Subcommittee today and to discuss briefly Connecticut's experience with insurance risk pools. Also, with me here today is Mr. John Sansone, who is the director of the Life and Health Division within the Department of Insurance. If there is no objection, Mr. Chairman, I respectfully request that the entire text of my statement be inserted into the hearing record.

The Connecticut Comprehensive Health Care Plan (CHCP) was created by statute in 1975, and was the first insurance risk pool system created nationwide. Under our CHCP, every insurance carrier offering individual health insurance in Connecticut shall, as a condition of transacting health insurance, make available to every resident of the state an individual comprehensive health care plan, except to those who are both sixty-five years of age or older and eligible for Medicare. Each enrollee shall have a choice of a low option or high option deductible. The amounts of the respective deductibles may be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index. The current deductibles are $400, $1,000 and $1,500, double the originals. The actual selection of the deductible is made by the individual insured.

Individual plans may be made available through participation in the Health Reinsurance Association, or a residual market association. Premiums charged by plans other than those offered by the Health Reinsurance Association may not exceed premiums charged by the Association.

When the original legislation was adopted in 1975, it included a provision for the assessment of every self-insurer in our state. The purpose of the inclusion was to expand the financial base for underwriting any losses incurred in the operation of the plans. A Federal suit in the Second Circuit determined that this requirement violated the ERISA exemptions and, as consequence, this provision is no longer an applicable part of the law.

There are two major providers of the Comprehensive Health Care Plan in Connecticut: the previously mentioned Health Reinsurance Association, and Connecticut Blue Cross/Blue Shield (BC/BS). Initially, the premiums charged by both BC/BS and the Association were equal. However, as loss experience developed, BC/BS was able to maintain the same premium level while the Association's premiums increased. This more favorable loss experience was probably due to the open enrollment carried-out by BC/BS as opposed to the restrictive enrollment of individuals not otherwise insurable by the Association.

That early competitive edge enjoyed by BC/BS has tended to diminish, and the rates are now approximately equal. Last year, BC/BS requested and received approval for an overall rate increase of approximately 50-52%. When the program was first developed by the Blues, it was offered as simply another insurance program, and no restriction for enrollment. As a result, there was a broader base of insured, including a fair preponderance of good health insurance risks.

I believe that the major reason for the change, and the more comparable rates, is the mental health provisions in Connecticut's bill. The number of young people enrolled in the program and availing themselves of this benefit, up to a million dollar limit, has substantially increased the losses by both providers. Because there was a larger number in this age group (19 and above), moving from their parents' group policies directly into a BC/BS plan, the reverse underwriting impact may have been more severely felt by BC/BS.

The coverage provided under the plan is specifically mandated by statute, and cannot be denied. No one can be refused, regardless of their medical condition, at the time of application. The only limitation is that coverage will not be available for one year on "pre-existing conditions". Benefits are paid at the rate of 80% of covered expenses, after application of the deductible portion selected by the insured. After an individual has paid $2,000, if single, or $4,000 in a family contract, in any year, the plan will pay 100% of the covered expenses incurred in that year. There is a maximum lifetime benefit of $1,000,000.

The act provides for the formation of group comprehensive health care plans, which are required to provide the same areas of coverage mandated for individual plans. Additionally, they must provide for continuation of coverage in a manner consistent with other group insurance policies, e.g., upon layoff, leave of absence or termination of employment for a period of 39 weeks, and for coverage of dependents for the same period upon death of the employee.

The health plan is administered through the auspices of a nonprofit entity, the Health Reinsurance Association. All accident and health insurers doing business in the state, as condition of their authority to transact business, must be members of the Association. The business of the Association is conducted through a board of seven directors, whose selection is approved by the insurance commissioner. The Association, in addition to its general powers, is given specific authority to establish appropriate rates, scales of rates, rate classifications and rating adjustments. The rates are "not to be unreasonable in relation to the coverage provided and the operational expenses of the Association". It may also administer any type of reinsurance program, for or on behalf of participating members.

Members of the Association may select the particular risks it elects to have written by or through the Association. However, members are not permitted to select-out individual lives from an employer group to be insured. Although rates for coverage are not to be excessive, inadequate or unfairly discriminatory, consideration shall be given to the substantial extra morbidity and administrative expenses for Association risks. All rates are reviewed by an actuarial committee of five persons, each of whom is a member of the American Academy of Actuaries.

Following the close of the fiscal year, a determination is made of net premiums, reinsurance premiums less administrative expenses, and incurred losses. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in Connecticut during the calendar year.

At the present time, there are approximately 35,000 Connecticut residents insured under the Comprehensive Health Care Plan. It is a particularly attractive plan for those persons who suffer from mental illness which requires in-patient hospital treatment because of the 1,000,000 maximum limit available. Another area of coverage, and one that the insurers are most apprehensive about, is for the treatment of AIDS. It is estimated that the annual cost of treatment for this illness is approximately $50,000. The numbers of individuals who may require treatment is unknown, but it may be substantial.

The result of the Comprehensive Health Plan is the very beneficial effect of providing health insurance to many thousands of individuals who would otherwise be unable to obtain it. Thus, the problem of availability has been addressed. However, the question of affordability remains an important ingredient. Coverage for a husband and wife, age 50-54 with a dependent child, would be subject to an annual premium of between $3,660.00 to $6,149.00 depending upon the deductible chosen. The plan in Connecticut sustained an operating loss of $885,375.00 for 1986, which shall be assessed against the member insurers. To look at it another way, this loss comes-out to about twenty-eight cents for every resident in Connecticut.

Connecticut, unlike some programs in other states, does not provide for a premium tax offset, although a request for such treatment allows pool losses to be paid by the General Fund instead of assessment to individual members. Another unique characteristic of the Connecticut plan is its absolute open enrollment provision. There is no requirement that an individual be denied coverage in other programs before eligibility.

It is my understanding that negotiations are currently being carried-on by the insurance industry and employer self-insurers with an aim toward removing the ERISA exemptions and permitting self-insurance participation in the State of Connecticut. This expansion of the base makes good sense, and I would encourage continued discussions.

Once again I would like to thank you, Mr. Chairman, and other Members of this Subcommittee for the opportunity to speak on this important issue. John Sansone and I would be more than willing to answer any questions that you may have.

Chairman **Stark**. Thank you. Just a couple of questions to see if I understand.

In Connecticut, is this risk pool only for those who would otherwise be denied, or can anybody just opt for it as an individual policy?

Mr. **Gillies**. Persons may opt for it as an individual policy.

Chairman **Stark**. Is it price competitive?

Mr. **Gillies**. Initially it was. When the "Blues" were underwriting it, they found that they could competitively engage in this marketplace at considerable savings over the health reinsurance plan. However, with the enactment of COBRA and other legislation, what had occurred is the individuals aged 19 and so forth, that group, was moving out and the "Blues" found that that was a competitive edge.

They were a good risk, if you will. They were young people and a good insurable risk. Now, with the COBRA provisions available, where the insurance will simply be continued over an extended period of time, it is not so attractive and we are observing sort of a merging in of the poorer risks into this particular association. So it is no longer. The differential has narrowed down and there is no longer a competitive edge.

Chairman **Stark**. Just to get me into focus here, on page 5 you talk about coverage for a husband and wife, age 50 to 54, a dependent child, and so forth and so on. At the low end, or the high deductible, you are talking about $300 a month cost, and change.

What is an average large group participant cost in Connecticut? Is that a tough one?

Mr. **Sansone**. That is pretty undeterminable. The rates for a group are determined by the experience of the group, so you could have exactly the same plan at several different locations and the premium would be different depending on whether the average age of the person involved was 45, or as some banks have it, the average age is 24. They enjoy a very good premium.

Chairman **Stark**. Okay. Let's take a large Hartford insurance company. Maybe they underwrite their own. What are they?

Mr. **Sansone**. Well, if we could, Senator, the State of Connecticut, for example, the employees there, the cost is probably between $2,400 and $3,000 a year.

Chairman **Stark**. So is substantially less.

Mr. **Sansone**. Yes.

Chairman **Stark**. And at the high deductible end you might drop that to $200.

Do you think there would be any major change in cost if you could pick up all the self-insureds? Do you spread that enough so that the cost would come down?

Mr. **Sansone**. No doubt about it. Yes, sir.

Chairman **Stark**. What would that drop your premium, would you guess, on the low end? I mean the high deductible, but what would that be?

Mr. **Sansone**. Well, the premium would not change. It would be the spreading of the losses that occur over the year.

Chairman **Stark**. The premium would still pretty much stay where it is?

Mr. **Sansone**. It would stay high. Yes.

Chairman STARK. If you had this plan to design over again, if you could start fresh, what would you change? How would you do it differently?

Mr. GILLIES. Well, I think the original plan that did encompass the broader base as it was envisioned was how the plan should have been designed. And I think that, obviously, the legislature was of that opinion as well. I would say that the expansion of the base would be one of the principle things.

Chairman STARK. Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

In setting the rates, are you limited by some relationship between the rates which you set and those which are charged in the private sector? In some of these plans, for example, in some States, as I recall it, they will have a rate that let's say will be 150 percent of the going rate.

Mr. GILLIES. That is how ours is, 125 to 150 percent.

Mr. GRADISON. Of what?

Mr. GILLIES. Of the rate that is established by the general market, those that are in a regular insurance group policy plan.

Mr. GRADISON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. At some other time convenient to you, maybe you could give us some information on the use of the mental health benefit. It would be interesting to see.

Mr. GILLIES. We have found that to be a very substantial portion of the use of it, particularly, interestingly, in the young age groups. There are a lot of young people who are taking advantage of the in-patient kinds of care.

I do not know, but it well may be that because there is coverage, a physician will, in fact, prescribe in-patient treatment.

Mr. LEVIN. This is in-patient?

Mr. GILLIES. That is right. It is in-hospital.

Mr. LEVIN. It is not being used for psychiatric visits?

Mr. GILLIES. No. There the limit is $1,000. But there is a very substantial differential, and there is a real utilization of this particular coverage, and we have seen it in the request for premium increases that have been filed with the department. For example, the request for increased premium, last time by the health insurance, was approximately 30 to 35 percent above the current rate. But it was not approved by our Department because of the statutory limitation of 125 to 150 percent.

So, on the face of it, both "Blues" program and this health insurance are operating at a rather substantial loss factor which then is disbursed back to the members.

Mr. LEVIN. Could you provide any analytical materials for us to look through?

Mr. GILLIES. I would be very happy to do that.

Mr. LEVIN. One last question. You are no doubt looking ahead. If even half the worst happens with AIDS, what will happen to the viability of this approach?

Mr. GILLIES. Well, one of the things about the AIDS situation, we talk about AIDS as a program within this context. But for most of the general public out there they are already covered under their group health plan. So it is going to have an impact not just here, but on the group policies nationwide. And also, we are very, very concerned, and I know this is not the subject of your committee's inquiry, but we are also very concerned with the aspect of the life insurance industry.

They, interestingly enough, are the entity that have been most vocal in their concerns because of the immediacy. The health insurance problems are things that they perceive as a problem coming down the pike. The life insurance aspects of it they see as a problem right now.

Mr. LEVIN. But under this approach, people with no or limited coverage who have AIDS shift into this coverage?

Mr. GILLIES. Yes.

Mr. LEVIN. So this would represent the place within your framework where—

Mr. GILLIES. Absolutely. There would be a limitation. Ostensibly, the person who has been diagnosed as having AIDS would immediately apply for this plan, and he would have to have it. There would be a 1-year waiting period. And with a life-expectancy of——

Mr. LEVIN. There is a 1-year waiting period?

Mr. GILLIES. Well, you can enroll immediately, but for a pre-existing condition there is a 1-year delay before coverage is actually available.

Chairman STARK. On your State plan?

Mr. GILLIES. That is correct.

Mr. LEVIN. I did not realize that.

Well, it is unfortunately such a relevant issue that we need to face it.

Mr. GILLIES. Oh, indeed.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman STARK. Does your plan, just as a practical matter, do you have like 100 percent adverse selection? Do you just get the uninsurables? Or do you have people who just opt for it because it is a State plan?

Mr. GILLIES. We initially—correct me if I am wrong—but initially it was a plan that was opted for, primarily because of the way the "Blues" were treating it. With the COBRA legislation, which has enable persons to continue their group policies with the existing carrier, what we are seeing is a rather dramatic reduction in the numbers of persons who are actually availing themselves of this program, and within the group that is availing themselves of it, the high risk group.

So we expect to see the premiums, the cost of the program go up rather dramatically in the foreseeable future, because we are getting a small group, and they are the uninsurables, the high risks.

Chairman STARK. But if that were spread on, say an insurance premium tax or some other basis to everybody, including the self-insureds, basically that is the cost of the program then, right?

Mr. GILLIES. That is correct.

Chairman STARK. It is not efficiently managed. It is just those that the existing programs will not pick up because of selection.

Mr. GILLIES. That is correct. But if there are any other questions that come to mind afterwards——

Chairman **Stark**. Well, you have an able advocate in Congresswoman Kennelly, and of course, she is one of the principal advocates of this kind of legislation, and she has been educating all of us in this area and we hope to be able to do something to expand this concept to all 50 States soon.

Your State really does serve, I think, as a role model in this for the rest of us. We appreciate your interest in helping the rest of us do what is right.

Mr. **Gillies**. Thank you very much.

Chairman **Stark**. Thank you very much for being with us.

The committee stands adjourned.

[Whereupon, at 1:25 p.m., the hearing was adjourned.]

[Submission for the record follows:]

STATEMENT OF
THE NATIONAL FEDERATION OF SOCIETIES
FOR CLINICAL SOCIAL WORK, INC.

The National Federation of Societies for Clinical Social Work is pleased to have this opportunity to present the views of the clinical social work profession regarding direct reimbursement of clinical social workers under the Medicare program. The National Federation represents thousands of clinical social workers around the country who are engaged in providing mental health services to individuals, families and groups, in private practice, in group practice settings, in HMOs, PPOs, EPOs, IPAs, public and private clinics and agencies, and in hospitals.

Although the mental health delivery system in the United States has grown up around the availability of qualified mental health professionals, without regard to the discipline of the provider, Medicare will only pay for services rendered by a physician. The law does not even require that the services be performed by a trained mental health professional -- any physician will do. In this respect, the 20-year old Medicare program is out of step with the realities of today's mental health delivery system, which is universally recognized to consist of four "core disciplines" -- psychiatry, psychology, clinical social work, and psychiatric nursing. Consequently, many of the nation's elderly are often denied the freedom to select from a range of qualified providers simply because the therapist of their choice may be a clinical social worker and is excluded from the Medicare financing structure.

UNMET MENTAL HEALTH NEEDS OF THE ELDERLY

Several years ago, the President's Commission on Mental Health conducted an analysis of governmental policy in the area of mental health service delivery, with particular focus on underserved populations. Many older Americans were found to have insufficient access to services or to personnel trained to respond to the special needs of the elderly.1/ Moreover, the Commission found that the elderly have a greater need for mental health services than the general population (up to 25% of older persons are estimated to have significant mental health problems).2/

Since then, other studies and reports have confirmed the findings of the President's Commission. A recent General Accounting Office report determined once again that the elderly do not have adequate access to mental health services.3/ And a 1984 study by the Department of Health and Human Services found that less than 4 percent of psychiatrists' visits are provided to persons over age 65, even though this age group accounts for almost 20 percent of office visits generally.4/ Further, the study documents the fact that four out of five persons age 65 or older with a mental illness are seen by non-psychiatrist physicians.5/

THE NEED FOR FREEDOM OF CHOICE

Insufficient access to mental health services and to trained mental health professionals led the President's Commission to recommend that Medicare and other publicly financed mental health service programs should provide direct reimbursement to all independent qualified mental health professionals including the four core disciplines, who meet the requisite standards of education, experience and professional licensure/certification.6/ The fundamental point made by the Commission was that federal financing mechanisms should be based upon the appropriateness of care, not the discipline of the provider.7/

It is particularly ironic that Congress, on the one hand, has appropriated funds over the years to train clinical social workers, under such programs as the National Mental Health Act of 1946, and, on the other hand, has excluded them from participation in the Medicare delivery system:

> ". . . [A] major barrier to outpatient care for populations with special needs is imposed by the public mechanisms for financing their mental health care -- Medicare and Medicaid . . . . Federal financing mechanisms have often worked at cross-purposes to federally initiated service delivery programs."8/

It is also ironic that at the same time Congress has guaranteed the patient through the Medicare law "freedom of choice" in selecting a provider, it has restricted that choice to only one class of provider -- physicians.

The President's Commission on Mental Health has not been alone in urging that the mental health delivery structure allow the consumer "freedom of choice" in selecting among qualified providers. Several years ago, Lewin and Associates, Inc. published the results of a study prepared for the Federal Trade Commission on competition among health practitioners, which examined the influence of the medical profession on the health manpower market. The study concluded that one of the principal ways to broaden consumer choice, and to diminish the monopoly power of physicians, was to allow consumers the freedom to select among a variety of health professionals. "If carefully designed, a system based on broadened choice could preserve professional competency while increasing competition among providers on the basis of the service they provide, quality, and price."9/ The study warned that "unreasonable resistance to change in present manpower arrangements has, in some cases, prevented appropriate utilization of health resources and possibly raised the cost of care."10/

There is no basis for concern that expanding the provider pool to include qualified non-physician mental health professionals will adversely affect therapeutic outcome. To the contrary, research has demonstrated there is no measurable difference in outcome on the basis of provider discipline.11/

"Freedom of choice" can be a critical element in the patient's acknowledgment that he or she needs treatment, in the patient's actual resort to treatment, and in the relationship of trust and confidence in the psychotherapist necessary to make that treatment successful. Medicare beneficiaries should not be denied the opportunity to select from a range of qualified providers merely because the therapist of their choice is a clinical social worker, and not a physician.

THE FEHBP AND CHAMPUS EXPERIENCE

Other federally funded health insurance programs have recognized the importance of utilizing the services of clinical social workers and other qualified non-physician mental health professionals. A 1986 study conducted by the Office of Personnel Management examined the effects of providing direct reimbursement to clinical social workers and other non-physician providers under the Federal Employees Health Benefits Program (FEHBP). The results of the study were encouraging. OPM concluded there was no basis to anticipate adverse impact on cost or quality of care from mandating coverage of non-physician providers, including clinical social workers.12/

The CHAMPUS program reports a similar experience. In 1980 Congress directed CHAMPUS to conduct a demonstration project by including clinical social workers as independent providers of covered services for a period of two years, in order to assess the impact on cost and utilization. In 1982, following the experimental period, Congress authorized continuation of the independent provider status, based on the finding from the demonstration project that "no quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach.13/

COST OFFSETS OF MENTAL HEALTH TREATMENT

In past years, some opponents of freedom of choice have argued that expanding the available provider base will cause a large increase in utilization, at additional cost to the government. Even if utilization were to increase with the inclusion of clinical social workers in the Medicare provider base, overall program costs would not necessarily increase proportionately. To the contrary, the evidence strongly suggests that increased utilization would be offset by corresponding cost savings.

For example, the President's Commission on Mental Health concluded that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery. "[A]s a group, this research is most striking", the Commission reported. "Research from health maintenance organizations (HMO's), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs.14/

The Commission also determined that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than diagnosable illness.15/ A similar finding was reported by the Department of Health and Human Services, in its study report titled "The Hidden Mental Health Network."16/

An article published by Jones and Vischi of the Alcohol, Drug Abuse and Mental Health Administration, summarized the results of twelve separate studies which have demonstrated that the cost of providing mental health services was offset by a significant decline in medical utilization.17/

One of the most recent studies relating to the offset effect of mental health treatment on medical costs is a 1983 study on outpatient mental health treatment following the onset of a chronic disease. The findings indicate that outpatient psychotherapy beginning within one year of the diagnosis of one of four chronic diseases is associated with reduced charges for medical services by the third year following the diagnosis.18/ The authors conclude that the study "adds weight to the conclusion drawn from the reviews of the scientific literature that the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it."19/

CONCLUSION

It is clear that the cost of leaving the mental health needs of our elderly unattended are enormous both in human and social terms. From the standpoint of just the dollars and cents involved, it has to cost more to keep paying the physician, laboratory, x-ray, surgical and hospital bills to treat the symptoms of underlying mental and emotional problems which can be more effectively (and inexpensively) dealt with by a trained mental health professional -- physician or non-physician.

It is time that the Medicare delivery system recognize as independent providers clinical social workers and other qualified non-physician mental health professionals who are currently providing the majority of the mental health services throughout the country.

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